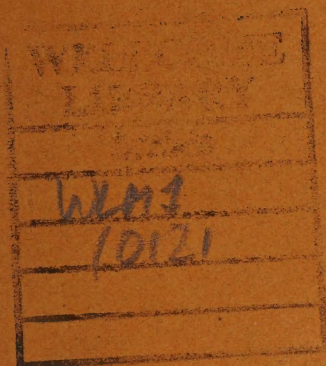




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EDITED BY

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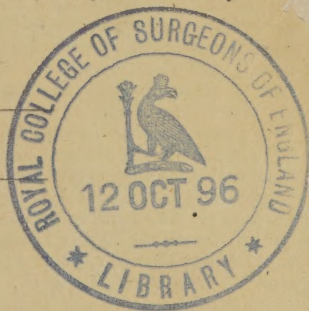
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“Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et
radii (ut in sensu fit) coire possint.”

FRANCIS BACON, *Proleg. Instaurat. Mag.*

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"In adopting our title of the *Journal of Mental Science*, published by authority of the *Medico-Psychological Association*, we profess that we cultivate in our pages mental science of a particular kind, namely, such mental science as appertains to medical men who are engaged in the treatment of the insane. But it has been objected that the term mental science is inapplicable, and that the terms, mental physiology, or mental pathology, or psychology, or psychiatry (a term much affected by our German brethren), would have been more correct and appropriate; and that, moreover, we do not deal in mental science, which is properly the sphere of the aspiring metaphysical intellect. If mental science is strictly synonymous with metaphysics, these objections are certainly valid, for although we do not eschew metaphysical discussion, the aim of this Journal is certainly bent upon more attainable objects than the pursuit of those recondite inquiries which have occupied the most ambitious intellects from the time of Plato to the present, with so much labour and so little result. But while we admit that metaphysics may be called one department of mental science, we maintain that mental physiology and mental pathology are also mental science under a different aspect. While metaphysics may be called speculative mental science, mental physiology and pathology, with their vast range of inquiry into insanity, education, crime, and all things which tend to preserve mental health, or to produce mental disease, are not less questions of mental science in its practical, that is, in its sociological point of view. If it were not unjust to high mathematics to compare it in any way with abstruse metaphysics, it would illustrate our meaning to say that our practical mental science would fairly bear the same relation to the mental science of the metaphysicians as applied mathematics bears to the pure science. In both instances the aim of the pure science is the attainment of abstract truth; its utility, however, frequently going no further than to serve as a gymnasium for the intellect. In both instances the mixed science aims at, and, to a certain extent, attains immediate practical results of the greatest utility to the welfare of mankind; we therefore maintain that our Journal is not inaptly called the *Journal of Mental Science*, although the science may only attempt to deal with sociological and medical inquiries, relating either to the preservation of the health of the mind or to the amelioration or cure of its diseases; and although not soaring to the height of abstruse metaphysics, we only aim at such metaphysical knowledge as may be available to our purposes, as the mechanic uses the formularies of mathematics. This is our view of the kind of mental science which physicians engaged in the grave responsibility of caring for the mental health of their fellow men, may, in all modesty, pretend to cultivate; and while we cannot doubt that all additions to our certain knowledge in the speculative department of the science will be great gain, the necessities of duty and of danger must ever compel us to pursue that knowledge which is to be obtained in the practical departments of science, with the earnestness of real workmen. The captain of a ship would be none the worse for being well acquainted with the higher branches of astronomical science, but it is the practical part of that science as it is applicable to navigation which he is compelled to study."—*Sir J. C. Bucknill, M.D., F.R.S.*

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1868. Orange, William, M.D. Heidelberg, F.R.C.P. Lond., C.B., 12, Lexham Gardens, London. (PRESIDENT, 1883.)
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1890. Oswald, Landel R., M.B., M.P.C., Medical Superintendent, City of Glasgow District Asylum, Gartcosh, N.B.
- * Palmer, Edward, M.D. St. And., M.R.C.P. Lond., M.R.C.S., 87, Harcourt Terrace, London, S.W.
1886. Parant, M. Victor, M.D., Toulouse. (*Corresponding Member.*)
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1892. Patterson, Arthur Edward, M.B., C.M. Aber., Assistant Medical Officer, City of London Asylum, Dartford.
1872. Patton, Alex., M.B., Resident Medical Superintendent, Farnham House, Finglas, Co. Dublin.
- * Paul, John Hayball, M.D. St. And., M.R.C.P. Lond., F.R.C.P. Edin.; Camberwell Terrace, London, S.E. (*Emeritus Treasurer.*)
1889. Peacock, Dr., L.R.C.P. and L.M. Edin., M.R.C.S. and L.S.A. Lond., Resident Medical Officer and Proprietor, Ashwood House, Kingswinford, Dudley, Staffordshire.
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1871. Pim, F., Esq., M.R.C.S. Eng., L.R.C.P. Ireland, Med. Supt., Palmerston, Chapelizod, Co. Dublin, Ireland.
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1873. Pitman, Sir Henry A., M.D. Cantab., F.R.C.P. Lond., Registrar of the Royal College of Physicians, Enfield, Middlesex. (*Hon. Member.*)
1896. Planck, Charles, M.R.C.S. Eng., L.R.C.P. Lond., M.A. Camb., Assist. Med. Officer, East Sussex County Asylum, Haywards Heath.
1877. Plaxton, Joseph Wm., M.R.C.S., L.S.A. Eng., Lunatic Asylum, Kingston, Jamaica.
1889. Pope, George Stevens, L.R.C.P. & S. Edin., L.F.P. & S. Glas., Assistant Medical Officer, Cane Hill Asylum, Purley, Surrey.
1876. Powell, Evan, M.R.C.S. Eng., L.S.A., Medical Superintendent, Borough Lunatic Asylum, Nottingham.
1891. Price, Arthur, M.R.C.S., L.S.A., M.P.C., Medical Officer H.M. Prison, Birmingham, 2, Handsworth New Road, Birmingham.
1875. Pringle, H. T., M.D. Glas., Medical Superintendent, County Asylum, Bridgend, Glamorgan.

1894. Rambant, Daniel F., M.D., Univer. Dub., Third Assistant Medical Officer, and Pathologist, Richmond District Asylum, Dublin.
1889. Raw, Nathan., M.D., M.P.C., Royal Infirmary, Dundee.
1893. Rawes, William, M.B. Durh., F.R.C.S. Eng., Assistant Medical Officer, St. Luke's Hospital, London.
1896. Ray, Matthew B., M.B., C.M. Edin., Pathologist and Assist. Med. Officer, West Riding Asylum, Wadsley, Sheffield.
1870. Rayner, Henry, M.D. Aberd., M.R.C.P. Edin., 2, Harley Street, London, W., and Upper Terrace House, Hampstead, London, N.W. (PRESIDENT, 1884.) (*Late General Secretary.*) (*Editor of Journal.*)
1890. Régis, Dr. E., 54, Rue Huguerie, Bordeaux. (*Corresponding Member.*)
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- * Robertson, Charles A. Lockhart, M.D. Cantab., F.R.C.P. Lond., F.R.C.P. Edin., late Lord Chancellor's Visitor, Gunsgreen, The Drive, Wimbledon. (*General Secretary, 1855-62.*) (*Editor of Journal, 1862-70.*) (PRESIDENT, 1867.) (*Hon. Member.*)
1895. Robertson, William Ford, M.B., C.M., Pathologist, Royal Edinburgh Asylum, West House, Morningside Asylum, Edinburgh.
1887. Robertson, G. M., M.B., C.M., M.P.C., Medical Superintendent, Perth District Asylum, Murthley.
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1895. Rolleston, Lancelot W., M.B., B.S. Durh., Junior Assistant Medical Officer, Middlesex County Asylum, Tooting, S.W.
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1860. Rorie, James, M.D. Edin., L.R.C.S. Edin., Medical Superintendent, Royal Asylum, Dundee. (*Late Hon. Secretary for Scotland.*)
1890. Rosenblum, Edward Emerson, M.B., B.S. Melbourne, Senior Assistant Medical Officer, Lunatic Asylum, Yarra Bend, Melbourne.
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1883. Russell, F. J. R., L.R.C.P. Irel., Tramore, St. Leonards-on-Sea.
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1866. Rutherford, James, M.D. Edin., F.R.C.P. Edin., F.F.P.S. Glasgow, Physician Superintendent, Crichton Royal Institution, Dumfries. (*Hon. Secretary for Scotland, 1876-86.*)
1887. Rutherford, W., M.D., Consulting Physician, Ballinasloe District Asylum, Ireland.
1896. Rutherford, Robert Leonard, M.D., Med. Supt., Digby's Asylum, Exeter.
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1894. Sankey, Edward H. O., M.A., M.B., B.C. Cantab., Resident Medical Licensee, Boreatton Park Licensed House, Baschurch, Salop.
1891. Saunders, Charles Edwards, M.D.Aber., M.R.C.P.Lond., Medical Superintendent, Haywards Heath Asylum, Sussex.
1873. Savage, G. H., M.D. Lond., 3, Henrietta Street, Cavendish Square, W. (late *Editor of Journal*.) (PRESIDENT, 1886.)
1894. Scanlan, William T. A., M.B., M.Ch. B.A.O.R.U.I., Assistant Medical Officer, District Asylum, Cork.
1862. Schofield, Frank, M.D. St. And., M.R.C.S., Medical Supt., Camberwell House, Camberwell.
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1889. Seoweroft, Walter, M.R.C.S., Senior Assistant Medical Officer, Royal Lunatic Hospital, Cheadle.
1880. Seecombe, Geo., L.R.C.P.L., The Colonial Lunatic Asylum, Port of Spain, Trinidad, West Indies.
1879. Seed, Wm., M.B., C.M. Edin., The Poplars, 110, Waterloo Road, Ashton-on-Ribble, Preston.
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1882. Seward, W. J., M.D., Med. Superintendent, Colney Hatch, Middlesex.
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1867. Shaw, Thomas C., M.D. Lond., F.R.C.P. Lond., Medical Superintendent, London County Asylum, Banstead, Surrey.
1880. Shaw, James, M.D., Donard House, Kensington, Liverpool.
1891. Shaw, Harold B., B.A., M.B., B.S., D.P.H.Camb., Senior Assistant Medical Officer, Isle of Wight County Asylum, Whitecroft, Newport, I. of W.
1882. Sheldon, T. S., M.B., Med. Supt., Cheshire County Asylum, Parkside, Macclesfield.
1886. Sherrard, C. D., M.R.C.S., Avalon, Eastbourne.
1877. Shuttleworth, G. E., M.D. Heidelberg, M.R.C.S. and L.S.A. Eng., B.A. Lond., late Medical Superintendent, Royal Albert Asylum, Lancaster; Ancaster House, Richmond Hill, Surrey.
1839. Sibbald, John, M.D. Edin., F.R.C.P. Ed., M.R.C.S. Eng., Commissioner in Lunacy for Scotland, 18, Great King Street, Edinburgh. (*Editor of Journal*, 1871-72.) (*Hon. Member*.)
1895. Simpson, Francis, M.R.C.S., L.R.C.P., Assistant Medical Officer, West Riding Asylum, Wakefield.
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1870. Skae, C. H., M.D. St. And., Medical Superintendent, Ayrshire District Asylum, Glengall, Ayr.
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1884. Smith, W. Beattie, F.R.C.S. Ed., L.R.C.P. Lond., Medical Supt., Hospital for the Insane, Ararat, Victoria.
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1883. Spence, J. B., M.D., M.C., Asylum for the Insane, Ceylon.
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1888. Stearns, H. P., M.D., The Retreat, Hartford, Conn., U.S.A. (*Hon. Member.*)
1894. Stevens, Thomas George, L.R.C.S.I., L.K.Q.C.P.I., Assistant Medical Officer, Central Criminal Asylum, Dundrum, Ireland.
1868. Stewart, James, B.A. Queen's Univ., F.R.C.P. Edin., L.R.C.S. Ireland, late Assistant Medical Officer, Kent County Asylum, Maidstone; Dunmurry, Sneyd Park, near Clifton, Gloucestershire.
1884. Stewart, Robert S., M.D., C.M., Assistant Medical Officer, County Asylum, Glamorgan.
1887. Stewart, Rothsay C., M.R.C.S., Assist. Med. Officer, County Asylum, Leicester.
1862. Stilwell, Henry, M.D. Edin., M.R.C.S. Eng., Moorcroft House, Hillingdon, Middlesex.
1864. Stocker, Alonzo Henry, M.D. St. And., M.R.C.P. Lond., M.R.C.S. Eng., Medical Superintendent, Peckham House Asylum, Peckham.
1881. Strahan, S. A. K., M.D., Assist. Med. Officer, County Asylum, Berrywood, near Northampton.
1868. Strange, Arthur, M.D. Edin., Medical Superintendent, Salop and Montgomery Asylum, Bicton, near Shrewsbury.
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1894. Sullivan, W. C., M.D.R.U.I., 74, Oakley Street, Chelsea, London, S.W.
1870. Sutherland, Henry, M.D. Oxon., M.R.C.P. London, 6, Richmond Terrace, Whitehall, S.W.; Newlands House, Tooting Bec Road, Tooting Common, S.W.; and Otto House, 47, Northend Road, West Kensington, W.
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1881. Tamburini, A., M.D., Reggio-Emilia, Italy. (*Hon. Member.*)
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1885. Tuke, T. Seymour, M.B., B.Ch. Oxford, M.R.C.S.E., Chiswick House, Chiswick; and 37, Albemarle Street, Piccadilly, W.
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1889. Turner, Alfred, M.D. and C.M., Assistant Medical Officer, West Riding Asylum, Menston, Yorkshire.

1890. Turner, John, M.B., C.M. Aber., Senior Assistant Medical Officer, Essex County Asylum.
1878. Urquhart, Alexr. Reid, M.D., F.R.C.P.E., Physician Supt., James Murray's Royal Asylum, Perth. (*Editor of Journal.*) (*Hon. Sec. for Scotland 1886-1894.*)
1894. Vincent, William James, M.B. Durh., Assistant Medical Officer, Borough Asylum, Nottingham.
1881. Virchow, Prof. R., University, Berlin. (*Hon. Member.*)
1881. Voisin, A., M.D., 16, Rue Séguin, Paris. (*Hon. Member.*)
1876. Wade, Arthur Law, B.A., M.D. Dub., Med. Supt., County Asylum, Wells, Somerset.
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1889. Warnock, John, M.D., C.M., B.Sc., M.R.C.S., Sanitary Department, Ministry of Interior, Cairo, Egypt.
1895. Waterson, Jane Elizabeth, M.D. Brussels, L.R.C.P.I., L.R.C.S. Edin., Official Visitor, Cape Town District Lunatic Asylums, Cape Town, South Africa.
1891. Watson, George A., M.B., C.M. Edin., M.P.C., Senior Assistant Medical Officer, City Asylum, Birmingham.
1885. Watson, William Riddell, L.R.C.S. & P. Edin., Govan District Asylum, Hawkhead, Paisley.
1880. Weatherly, Lionel A., M.D., Bailbrook House, Bath.
1880. West, Geo. Francis, L.R.C.P. Edin., Assist. Med. Officer, District Asylum, Omagh, Ireland.
1872. Whitecombe, Edmund Banks, M.R.C.S., Medical Supt., Winson Green Asylum, Birmingham. (*PRESIDENT, 1891.*)
1884. White, Ernest, M.B. Lond., M.R.C.P., City of London Asylum, Stone, Dartford, Kent.
1889. Whitwell, James Richard, M.D. and C.M., Assistant Medical Officer, West Riding Asylum, Menston, near Leeds.
1883. Wiglesworth, J., M.D. Lond., Rainhill Asylum, Lancashire.
1895. Wilcox, Arthur William, M.B., C.M. Edin., Second Assistant Medical Officer, County Asylum, Hatton, Warwick.
1887. Will, Jno. Kennedy, M.B., C.M., M.P.C., Bethnal House, Cambridge Road, E.
1862. Williams, S. W. Duckworth, M.D. St. And., L.R.C.P. Lond., Chislehurst, Marlboro' Road, Bournemouth.
1893. Wills, Ernest, M.D. Lond., M.R.C.P. Lond., Second Assistant Medical Officer, London County Asylum, Claybury.
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1896. Wilson, Robert, M.B., C.M. Glas., Nailsworth, Gloucestershire.
1885. Wilson, G. V., M.D., Assist. Med. Officer, District Asylum, Cork.
1895. Wilson, James, M.A., M.B., C.M., Assistant Medical Officer, Wilts County Asylum, Devizes.
1875. Winslow, Henry Forbes, M.D. Lond., M.R.C.P. Lond., 14, York Place, Portman Square, London, and Hayes Park, Hayes, near Uxbridge, Middlesex.
1869. Wood, T. Outterson, M.D., M.R.C.P. Lond., F.R.C.P., F.R.C.S. Edin., 40, Margaret Street, Cavendish Square, W.
1894. Wood, Guy Mills, M.B. Durh., Assistant Medical Officer, County Asylum, Rainhill, near Prescot, Lancashire.
1873. Woods, Oscar T., M.B., M.D. (Dub.), L.R.C.S.I., Medical Superintendent, District Asylum, Cork. (*Hon. Secretary for Ireland.*)

Members of the Association.

xvii

1885. Woods, J. F., M.R.C.S., Med. Supt., Hoxton House, N.
 1877. Worthington, Thos. Blair, M.A., M.B., and M.C. Trin. Coll., Dublin, Med.
 Supt., County Asylum, Knowle, Fareham, Hants.
 1865. Wyatt, Sir William H., J.P., Chairman of Committee, County Asylum,
 Colney Hatch, 88, Regent's Park Road. (*Hon. Member.*)
 1862. Yellowlees, David, M.D. Edin., F.F.P.S. Glasg., LL.D., Physician Superin-
 tendent, Royal Asylum, Gartnavel, Glasgow. (PRESIDENT, 1890).
 1882. Young, W. M., M.D., Assist. Med. Officer, County Asylum, Melton, Suffolk

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List of those who have passed the Examination for the Certificate of Efficiency in Psychological Medicine, entitling them to append M.P.C. (Med. Psych. Certif.) to their names.

Adamson, Robert O.
Adkins, Percy.
Ainley, Fred Shaw.
Ainslie, William.
Alexander, Edward H.
Anderson, John.
Anderson, A. W.
Anderson, Bruce Arnold.
Andrieson, W.
Armour, E. F.
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Ballantyne, Harold S.
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Bond, C. Hubert.
Bond, R. St. G. S.
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Boyd, James Paton.
Bristowe, Hubert Carpenter.
Brodie, Robert C.
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Bruce, John.
Bruce, Lewis C.
Brush, S. C.
Bullock, William.
Cameron, James.
Campbell, Alfred W.
Campbell, Peter.
Calvert, William Dobree.
Carmichael, W. J.
Carruthers, Samuel W.
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Chambers, James.
Chapman, H. C.
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Conolly, Richard M.
Cooper, Alfred J. S.
Cope, George Patrick.
Conry, John.
Corner, Harry.
Couper, Sinclair.
Cowan, John J.
Cowie, C. G.
Cowie, George.
Cowper, John.

Cox, Walter H.
Craig, M.
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Fennings, A. A.
Ferguson, Robert.
Fitzgerald, Gerald
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Goodall, Edwin.
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Grant, Lacklan.
Gray, Alex. C. E.
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Halsted, H. C.
Haslam, W. A.
Hassell, Gray.

- Hector, William.
Henderson, Jane B.
Henderson, P. J.
Hennan, George
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Hicks, John A., jun.
Hitchings, Robert.
Holmes, William.
Hotchkis, R. D.
Howden, Robert.
Hutchinson, P. J.
2 Hyslop, Theo. B.
Ingram, Peter R.
Jagannadham, Annie W.
Johnston, John M.
Kelly, Francis.
Kelso, Alexander.
Kelson, W. H.
Ker, Claude B.
Kerr, Alexander L.
Keyt, Fred.
King, Frederick Truby.
Laing, J. H. W.
Laing, C. A. Barclay.
Law, Thomas Bryden.
Leeper, Richard R.
Leslie, R. Murray.
Livingstone, John.
Lloyd, R. H.
Low, Alexander.
Macdonald, David.
Macdonald, G. B. Douglas.
Macdonald, John.
McAllum, Stewart.
Macevoy, Henry John.
Mackenzie, Henry J.
Mackenzie, John Cumming.
Mackenzie, William L.
Mackenzie, William H.
Mackie, George
MacInnes, Ian Lamont.
Macmillan, John.
5 Macnaughton, Geo. W. F.
Macneece, J. G.
Macpherson, John.
Mallannah, Sreenagula.
Marsh, Ernest L.
Martin, Wm. Lewis.
Meikle, T. Gordon.
Melville, Henry B.
Middlemass, James.
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Mitchell, Charles.
Monteith, James.
Moore, Edward Erskine.
1 Mortimer, John Desmond Ernest.
Myers, J. W.
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Nairn, Robert.
Neil, James.
Nixon, John Clarke.
Nolan, Michael James.
Norton, Everitt E.
Orr, David.
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Patterson, Arthur Edward.
Pearce, Walter.
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Pieris, William C.
Pilkington, Frederick W.
Piteairn, John James.
Porter, Charles.
Price, Arthur.
Pring, Horace Reginald.
Rainy, Harry, M.A.
Rannie, James.
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Reid, Matthew A.
Renton, Robert.
Rice, P. J.
Rigden, Alan.
Ritchie, Thomas Morton.
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Robson, Fredk. Wm. Hope.
Rose, Andrew.
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Rust, James.
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Scott, William T.
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Simpson, John.
Simpson, Samuel.
Skae, F. M. T.
Skeen, George.
Skeen, James H.
Slater, William Arnison.
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Symes, G. D.
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Thomson, George Felix.
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Turner, W. A.
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Walker, James.
Waterston, Jane Elizabeth.
Watson, George A.
Welsh, David A.
West, J. T.
Wickham, Gilbert Henry.
Whitwell, Robert R. H.

Will, John Kennedy.

Williams, D. J.

Williamson, A. Maxwell.

Wilson, John T.

4 Wilson, G. R.

Wilson, James.

Wilson, Robert.

Wood, David James.

Yeoman, John B.

Yeates, Thomas.

Young, D. P.

Younger, Henry J.

Zimmer, Carlo Raymond.

1 To whom the Gaskell Prize (1887) was awarded.

2 To whom the Gaskell Prize (1889) was awarded.

3 To whom the Gaskell Prize (1890) was awarded.

4 To whom the Gaskell Prize (1892) was awarded.

5 To whom the Gaskell Prize (1895) was awarded.

6 To whom the Gaskell Prize (1896) was awarded.

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PART I.—ORIGINAL ARTICLES.

*Insanity of Conduct.** By GEO. H. SAVAGE, M.D., F.R.C.P.
London, and C. MERCIER, M.B. London.

DR. SAVAGE.

Gentlemen,—I feel that some apology is due in bringing before you a series of rather trivial cases of mental disorder, in which there is nothing very new, and whose interest really lies in their being placed together for special consideration. Experience teaches me that one may often learn more from the slighter deviation from health than from the more serious perversions. In the former one may watch the details much more readily than one can in the latter.

Most of you, having lived with the insane, know how much more disorder may be present than may be evident to the casual examiner; how many persons in asylums are more mad than their speech would connote. With the sane we recognize that their *lives* are more in evidence than their speech, and their relationship with the world is rather to be judged by conduct than by words. A man may smile and be a villain, and he may certainly be a precious talker and yet a pernicious person. We experts in lunacy recognize this, but the world, more especially the legal world, is loath to allow that insanity is often to be judged of by the acts of the individual rather than by his words.

They all allow that an incoherent person, or one with a marked delusion, may commit an act of violence as a result of the mental disorder, and be excused thereof; but they will not admit—if even they recognize—that an act may be the one insane symptom.

Dr. Mercier and I have in view the demonstration that there are many insane conditions in which the conduct of the

* Read at the Annual Meeting of the British Medical Association, London, 1895.

patient must be the gauge of disorder, and that though we do not ignore intellectual or sensory disorders, yet beside and apart from these the conduct of the patient must be studied and recorded.

We do not want to form and name a fresh group of insanity of the Ethically Insane. The battle as to the existence of moral insanity is not over, in England there being still physicians of eminence who do not admit there is any such ailment apart from sinfulness.

We, on our part, wish to re-state our belief in moral insanity, and to go one step further and show that breaches of the conventional as well as the moral laws of society may be but symptoms of disorder or disease of the higher nervous system.

Disorder of conduct will be found to be a symptom of various forms of mental disorder, and will occur in varying degrees.

By our nervous system we guide ourselves, and this system being out of order we may lose our way.

In some of the cases referred to, moral defect is more evident, while in others the change is noticed mostly in the behaviour.

The term, disorder of conduct, must be recognized as varying with the individual; what is abnormal in one being natural in another. Conduct, whether normal or not, represents the motor side of a higher reflex act, and must be looked upon as reaction to the stimuli from without; but this part of the subject may be left for the present.

In studying the disorders of conduct I shall give examples occurring in hysteria, others associated with malingering (hysterical and hypochondriacal), while in some the disorder is associated with ingenuity or even genius; in whom there is a lobsidedness which misleads the patient. In some other cases the disorder precedes some other form of mental trouble, such as mania or melancholia.

In some monomanias, such as kleptomania, the symptoms may be chiefly seen in the conduct of the patient.

In a large group of cases that have passed through one or more serious mental illnesses, disorder of conduct may be the chief defect which is left, the patient being fairly intelligent, without delusions, etc., and yet insane in behaviour. The cases given in brief are as follows:—

Miss M., whose mother, the widow of a professional man, saw me at the request of Dr. S. early in 1895, having sent

me a very large budget of letters of all sorts. The girl is 28, single, said to be bright, pretty, and accomplished. It seems that where they lived a cousin got engaged to be married; he soon began to receive anonymous letters, then some other young men received similar letters; these contained all sorts of odd remarks and vague threats. In one, was the drawing of a coffin, with "Dead the mother, dead the child." Suspicion fell on the house of Mrs. M., and after much talk it seems, according to the present tale, that the three younger sisters thought the best way was for one of them to say she did it. This was done by the second, B. They say they thought as the eldest was much in society and was going to be bridesmaid they would screen her. The mother seems not to have known of this then. The eldest daughter went to be governess to a child of a lady of title, and she seemed to get on all right; but later anonymous letters were renewed. Then it was found she was saying many things which were not true, thus, that she had won an open scholarship at a college and was going to have a holiday; that she had been riding and driving a pair; that she had many invitations to stop with friends (the statements in letters were always of the grand kind likely to please her mother). I have seen some letters remonstrating with her mother for making inquiries as to the truth of some of her statements. Beside all this, some time before, she had had a peculiar skin affection, which was proved to have been produced by herself by burning with hair-curlers; she also made the sore bleed, and she seemed to pay no attention to the wound. This skin affection recently reappeared. She has had no permanent love affair, but has had offers of marriage. The whole thing looks like grave hysteria.

There was most supreme self-confidence, apparent affection for her relations, and her vagaries seemed at times to have been associated with a desire to please her mother. She had great general ability, and was able to perform her duties as governess and to mix in good society without displaying any peculiarity. Yet all the time she was leading a double life. She later became engaged to be married, and the other troubles passed away. The chief points in the case were malingering and mischief-making in a guise of high moral and intellectual culture depending on hysteria.

Disorder of Conduct preceding an Attack of Melancholia.

Miss B., aged 30, brother insane, who had been living the life of an ordinary English lady with relations and friends, complained of sores in the palms of both hands, and later of similar sores which occurred symmetrically elsewhere. She professed the utmost anxiety to have these sores cured, and was taken at considerable expense to leading general and special medical men, and so ingeniously had she contrived that for some time they did not discover that these symmetrical sores were self-inflicted, and a leading consultant had drawings of the strange malady prepared. Later the patient became sleepless, refused her food, was suicidal, trying to throw herself into the fire, and also talking of killing herself if ever she got the chance. With an attack of influenza temporary mental improvement followed, and further amelioration followed change of residence from one asylum to another.

In relationship to this case, and the one of Miss M., I would say that it is not at all uncommon to meet with hysterical young women who put themselves to great personal torture without any apparent object, for in some I have known injuries produced artificially and most artfully concealed, just as one has known of hysterical patients who ate and drank their excretions without any possible object in view. Allied to the last, I would consider those cases which seem to partake in part of hysteria and in part of hypo-chondriasis, such cases feigning disease or inflicting local or general injuries upon themselves. Some such cease to take any interest in themselves or their surroundings; men who have been enthusiastic lovers of work or sport, who have been active and useful, without illness or visible external or internal cause, "give up." These patients repudiate any feeling of melancholy, and in some cases will defend their indolence and their change of habit. In some cases, doubtless, the individual is naturally of selfish temper, and has been capable of work only when stimulated from without, or when from mere vital energy there was a desire to do something; yet such cases may exhibit absolutely no signs of mental disorder or weakness apart from their disinclination to work or to fulfil their duties. In some, physical disorder may suffice as the starting point, and may throw the patient out of step, as it were, and he is never able to recover his lost position, and seems incapable of trying.

Disorder of Conduct as an Early Stage of Mania.

The following is an example of a very common form of disorder chiefly met with in young neurotic persons, and may be associated with periods of depression, so that the patient passes through cycles of mental disorder which may lead to a habit of instability, which may become permanent.

Some of these patients belong to the class of eccentric geniuses, who are so nearly allied to the insane.

A medical student, aged 22, whose mother was insane, who had always been steady, and who had lived with his relations, after working rather hard for an examination was for a time sleepless and feeling out of sorts. He then began to do extravagant and unusual things. He offered marriage to several ladies, he spent money recklessly, buying useless things, he dressed "loudly," and assumed the airs of a man about town. He no longer submitted to the ordinary home discipline, and his language was often violent and profane. Yet during several prolonged interviews it was quite impossible to discover any defect of intellect, his memory being clear, and while admitting that his conduct might give rise to misconceptions, yet he showed no signs of delusion of any kind. This patient went as a voluntary boarder to an asylum, where lately he became maniacal. He recovered, resumed his professional work, but a year later there was a repetition of the disorder of conduct. Of course I recognize that in this case all the disorder depended upon defect of higher control, yet the study of disorders of conduct would be incomplete without reference to such cases.

Inventive Genius with Insanity of Conduct.

Mr. C., civil engineer, 38; married; seen early in 1895; belonging to neurotic family, and himself having been once in an asylum. Of more than usual ability in his profession, well educated, and with good prospects, without any physical signs of disease and without intemperance, he began to do extraordinary things and to cause trouble to his wife. He would possess himself of her jewellery, he would ingeniously pick locks, remove valuables, and again close the doors without leaving any signs of what had been done. Well knowing and recognizing that he had no money he would stop at costly hotels, and without being extravagant would still live comfortably. He would travel by rail without tickets, and always with plausibility would avoid the

consequences of his acts. In conversation nothing could be more reasonable than his defence of his conduct and his enunciation of his schemes, so that in his case no defect of mind, memory or understanding could be detected, though his conduct was anti-social, and was ordinarily considered to be criminal. I believe this patient to be passing through a stage of moral disorder, which will eventually increase and be associated with other forms of disorder of the mental class.

Dishonesty and Sexual Perversion in a Clergyman.

Clergyman of 40, born in the tropics, his mother at time of birth suffering from severe nervous shock. As a child he was somnambulistic; he had also chorea; he was bright, clever, and not differing from other boys, except that he was a precocious onanist. From school he went to University, where he did very well, and later was ordained; he married at 23 a woman much older than himself, from whom he soon separated. After this, though following his profession in a desultory way, his conduct became markedly abnormal. He pilfered jewels, rings, purses or petty cash without any definite necessity for the money, being fully conscious of the danger he ran legally, and yet being quite unable to refrain. With this disorder he also developed perverted sexual feelings, being attracted by men, while women were antipathetic to him. He, as a result of petty thefts, was sent to gaol on more than one occasion, and also voluntarily he placed himself in an asylum to prevent him from committing other crimes. This patient was without any apparent intellectual defect, he was brilliant and eloquent as a preacher, and, while fully recognizing the consequences of his acts, was quite incapable of controlling them.

Tendency to Drink and Debauchery in a Lady of Position.

Miss C., aged 33, had been living with relations, being well off; she had plenty of general ability, with no defect of any faculty of mind or body; at one time she was said to have had some uterine trouble; no amount of influence would induce her either to lead a moral or temperate life, and yet there seemed to be nothing specially abnormal in her desires, her memory, or in her ordinary powers of control. Though repeatedly under the influence of alcohol, and although by her conduct alienating her friends, yet it was quite impossible to treat her as of unsound mind. I recognize that in introducing such a case as this I am stretching the

bounds of disorder of conduct as a neurosis very far, but I am daily impressed by the fact that certain people are drunken or dissipated against their will, and as the result of the tyranny of their organization.

Chronic Insanity Chiefly Marked by Disorder of Conduct.

Captain P., aged 50, who has been for 25 years in an asylum, and whose mental capacity appeared to be perfectly normal. He has a perfect memory for both recent and distant events; he conversed intelligently on science and art, recognizing the latest discoveries and their due importance. He had knowledge of his family, but at once said that a quarter of a century removed from the world prevented him having an interest in his relations. I am told that at first when admitted to the asylum he was extremely violent and dangerous, that still, though to outward appearances sane, his general habits and ways are those of a weak-minded person. He has passed into a condition of perfect indifference as to his personal relations, and appears to be unable to direct himself or his affairs.

Rev. L. P., brother of the above, who has also been in an asylum for a quarter of a century, though not so intelligent as his brother, yet he was quite able to converse freely about the past, about his present position and his future prospects. His profession occupied his chief care, and he appeared to be deeply read in Scripture. He had some rather brilliant notions for doing good to society, more particularly to the poor, which, though hardly practical, were certainly not insane. This gentleman, like his brother, exhibits, in his ways and habits, evidence of disorder in conduct and inability to fit into his proper social surroundings, and it is noteworthy that in many asylums there are large numbers of "wrecks" who are alien to society and unfit to return to family or relations as a result of defective power to direct their conduct.

Kleptomania as an Insanity of Conduct.

I have met a considerable number of patients belonging to nervous families who, under depressing nervous conditions, have developed kleptomania. In these cases it is quite common to meet with perfectly normal mental states associated with inability to refrain from pilfering. In such cases experience of punishment for faults has no power to control in any way. Patients recognize the

effects of their actions and can reason clearly and fully about them and yet cannot refrain from their repetition. Such cases have been described as depending upon uncontrollable impulse, and no particular harm results from so considering them, though I believe it to be more natural to place them with the cases in which disorder of conduct is the chief indication of nervous disease. Cases being so frequent, and being well recognized, renders it unnecessary for me here to give examples.

. In completing the subject I think it necessary to refer to certain cases in which the conduct is perfectly normal, while there is evident intellectual defect. Thus, in one case a young lady who was heir to considerable property, who belonged to a nervous degenerating family, who had been placed under the most favourable conditions for education and development, was still, when by age entitled to her property, quite incapable of doing the simplest sum or of making the most ordinary money transaction. She understood her incapacity, and allowed others to act for her. She was equally incapable of reading or taking in from books any simple abstract notion, and yet she was able to conduct herself so well as the result of her training as to pass in society as a quiet, rather shy, but not evidently mentally defective person.

Another similar case was that of a young man also entitled to property, who, though capable of behaving himself in a way which impressed strangers with the fact that he was not only intelligent, but in some particulars accomplished, yet, as far as ordinary education was concerned, he was incapable of development. In his case we have the correlative of those cases of genius associated with defect of power of control, for he was brilliant along a special line and yet incapable of abstract education.

In the last case to which I will refer a young man of position passed through the ordinary English systems of education, but at the end was incapable of writing a letter such as an ordinary boy of six would write, and was equally incapable of learning from books, and yet was able to mix with his social equals without their detecting anything abnormal. Doubtless those practising chiefly among idiots and imbeciles can record similar instances of persons who, being intellectually weak, yet by their conduct do not give evidence of this weakness.

And now, gentlemen, for the conclusion of the matter. We recognize that insanity affects all the actions of a man, and cannot be localized as a special entity. It shows itself in manifold ways, and I have specially brought before you cases in which the conduct of the patient was more eloquent of his disorder than was his speech. I recognize that we cannot trace the underlying disorder in many cases of insanity, but yet we must lay sufficient weight on the fact that madness may show itself first or chiefly in acts.

The lawyer will be hard to persuade that the incriminated act shall stand apart as a symptom of insanity, and the public will be almost as infidel, yet we must not shrink from asserting what we believe to be true. Insane acts may follow insane delusions which are evident, or insane acts may follow concealed delusions, this occurring more particularly in cases of mania of persecution with highly developed caution. Again, insane acts may precede evident unsoundness of the mental faculties; they may occur as a kind of habit, and may have no apparent relationship to the mental state; in some cases they seem to be an altogether abnormal reaction to the ordinary stimuli.

DR. MERCIER.

The following case came last year under the observation of Dr. Savage and myself:—A gentleman, now about 60 years of age, had had an exceptionally brilliant career. He distinguished himself at Oxford, not only by taking a first class, but by achieving among his contemporaries a very high reputation for ability. Entering a profession, he not only rose to a high position, but published works which gained for him a European reputation. He was chosen on important occasions as special correspondent of *The Times*. He filled various appointments with ability and success. Throughout his career he displayed abundant evidence of exceptional intellectual attainment. At length something happened which compelled him to retire from his profession, and thereafter, for ten or twelve or more years, he lived a life which was strikingly at variance with his former career.

He now eschewed altogether the society of his equals in social standing, and lived in solitude, a solitude relieved only by the companionship of the family of an old manservant who looked after him, and broken by occasional

outbreaks of a nature which eventually brought him under care.

From his early college days he had been addicted to drinking, and to drinking in a peculiarly sottish manner. It was not at wine parties with his fellow students that he got excited by companionship and exceeded the bounds of prudence. He drank in solitude and with deliberation; drank to great excess; but was able to carry his drink so well that he rarely got into trouble. Throughout his career his tendency to drink, and his ability to conceal the effects of drink, continued; but after his retirement from active life his alcoholic debauches became complicated by a new manifestation. They became accompanied by manifestations of sexual perversion.

From time to time, at intervals of a few weeks, he would leave his home suddenly, without notice to his servant, without preparation, and without luggage; and, after a few days, or a week or more, he would be found staying at an hotel, or in some disreputable haunt, surrounded by youths of the lowest class and the most abominable propensities, with whom he had been carrying on his abnormal and criminal practices. Again and again his medical attendant and his servant rescued him from this position; again and again his disreputable associates extorted from him large sums of money by way of blackmail; again and again he escaped from a criminal prosecution by the skin of his teeth.

It was after one of these periodical outbreaks that he first came under my observation, his medical attendant being convinced after long acquaintance with him that he was insane. Upon the most careful examination I failed to discover in his conversation any evidence of mental defect or of mental disorder. He was not only rational, but was courteous, gentlemanly, and impressed one as being a man of acute intellect and a thorough man of the world. He was neither excited nor depressed, he was not suspicious, nor irritable, nor confused, nor did he display in conversation any mental peculiarity. He was quite uncertifiable, and I was unable, and refused, to sign a certificate with regard to him. But there were two or three circumstances which were distinct evidence of insanity, though they did not constitute proof sufficiently cogent to embody in a certificate. One of these was that he was in the habit of writing numerous letters to his associates in vice; letters of the

most revolting description, in which he described in the plainest terms and with the most unctuous delight the practices in which he and they were accustomed to indulge. Some of these letters he posted, but many of them he left openly lying about in different parts of his house, for the perusal of his servant, the wife and daughters of his servant, or any one who might chance to pick them up. They were not even enclosed in envelopes, but were freely exposed to view. Another circumstance was that he appeared wholly insensible to the turpitude of his conduct, and to the horrible nature of his efforts to corrupt innocent boys; though he was quite fully sensible of the danger which he incurred of coming within the operation of the criminal law. A third peculiarity was the astoundingly voluminous character of his correspondence. He could not write a letter upon the simplest matter without filling page after page and sheet after sheet with writing, all of it well and grammatically expressed, well written, and more or less germane to the subject on which he was engaged; but not only wearisome in the extreme, but positively abnormal in its extraordinary voluminousness. I purposely exclude from consideration such matters as his personal uncleanness and other signs which were observable only after his debauches of drunkenness, and were obviously due to them. At these times he was, as is so commonly the case, easily certifiable, and after one of these debauches he was certified and admitted upon an urgency order. Upon a petition being presented to a magistrate for a judicial reception order the magistrate refused to make such an order, the signs of insanity due to drink having in the meantime cleared away.

Subsequently he became the subject of an inquisition in lunacy, and there being no real opposition on the part of the patient, who saw that his only alternative to his being found lunatic was his conviction by a common jury at the Old Bailey, the Master in Lunacy, with some misgiving, found him insane.

Some months after the inquisition the insanity of the patient became in issue at a trial before one of the ablest of the Chancery judges, who decided after a long and patient hearing that the insanity was proved up to the hilt. The only fact of importance that was proved at this trial in addition to those above given, was that the patient had allowed a young lad to obtain a great influence over him,

had not only given the lad large sums of money, but had placed himself largely under the lad's control, and ordered his conduct much as the lad directed him.

The foregoing case is instanced as a sample of a class of cases in which insanity is evidenced mainly—practically entirely—by conduct, and in which disorder of mind, though not entirely absent, occupies an altogether subordinate position. It is now 14 years since I submitted in the “*Journal of Mental Science*” the doctrine that insanity is not a disorder of mind, and a claim that disorder of conduct should enter as an integral part into our concept of what insanity is. Cases like those cited by Dr. Savage, in which disorder of conduct is practically the only evidence of insanity, are not uncommon; and the time appears now to be ripe for again bringing forward this doctrine. The position that is here maintained is that insanity is not a disorder of mind; that there may be disorder of mind without insanity; and that in insanity there is much besides disorder of mind. At the same time I must not be understood as saying that there can be insanity without disorder of mind. Doubtless whenever there is sufficient disorder of conduct to constitute insanity, some disorder of mind is present. The position is that there is no insanity without disorder of conduct, and that in some cases of insanity the disorder of mind is so inconspicuous that practically we have to depend for evidence of insanity entirely upon the disorder of conduct.

The question whether the unnatural sexual proclivities which this patient displayed, of themselves constitute insanity, is one which cannot be answered in this general form. The question must in every case be decided upon the circumstances of that case. Here we trench, as alienists so often have to trench, upon the provinces of the jurist and the ethical philosopher. We are scarcely yet in a position, or, if we are, this is not the occasion, to lay down in general terms the distinctions between insanity, crime, and vice. This we shall probably all admit—that a craving so perverted and unnatural in character, and of such intensity that neither the frequent and exorbitant demands of blackmailing associates, nor the terrors of the criminal law—the infamy of trial and the fearful severity of sentence—are able to counteract it, that such a craving is essentially morbid in its nature; that the existence of such a craving

is as much evidence of disorder of mind as is the existence of a craving to commit suicide. Those who regard the existence of such a craving as not of itself necessarily a proof of insanity, must admit that disorder of mind may exist without insanity.

Evidence to the same effect is forthcoming in those cases of imperative ideas to which the late Dr. Hack Tuke devoted a paper at the Neurological Society last year. "I refer," he said, "to those cases in which a person would not be regarded as insane. I am anxious to bring into prominent relief the absolute innocuousness and sanity of a large number of imperative ideas." He then related many cases, of which I need quote only one, that of a man who was tormented by the absurd idea that he was pregnant. He would laugh at the notion and say that of course he knew there was nothing in it, but he could not rid himself of it. In such a case there is undoubtedly disorder of mind, but we have Dr. Tuke's strenuous assertion that such a person is not to be regarded as insane. The numerous cases of hallucination in the sane are cases in point. An hallucination is most certainly a disorder of mind, and, as certainly, it by no means necessarily implies insanity. Very many cases have been recorded of hallucinations experienced by persons who recognized their unreal character, and probably most of us have had one or two such experiences.

On the other hand there may be disorder of conduct without any discoverable disorder of mind, save only in the motive which prompts the conduct, and this disorder of conduct may or may not amount to insanity.

Instances of disorder of conduct that do not amount to insanity are given by Dr. Hack Tuke in his paper on "Imperative Ideas," and are parallel with the disorders of mind that have already been dealt with. The following instance, taken from that paper, is the only one that need be given:—A gentleman, in attempting to open a door which he has no reason to suppose is stiff—for example, in his own room—employs unnecessary force to do so, and strikes the architrave in order to assist his efforts to ease the door. Other instances are found in those cases of impulsive insanity which, rare as they are, are incontestably proved to exist. I refer to those cases in which the patient has an overpowering craving to commit some act that he abhors, a craving to which he at length yields, in spite of his struggles to resist. In such cases the act is the only

evidence that we have of insanity, and the sole mental disorder is the craving to commit the act. No other indication of unsoundness of mind may be present.

The case quoted at the beginning of this paper is another instance of disorder of conduct of itself amounting to and constituting insanity, the accompanying disorder of mind being a negligible quantity. The lunatic was thoroughly intelligent, and it was *not* the common case of the intelligent lunatic, who can converse sensibly and even brilliantly, and whose insanity no one would suspect until the subject of his delusions is touched upon. Here there were no delusions. The feature in the case that raised the question of insanity was the conduct, and whatever evidence of mental defect there was, was not of itself sufficient to embody in a certificate with any chance of its being accepted by a judicial authority. As a matter of fact, the evidence did come before a judicial authority, and was by him rejected as insufficient. There was, in fact, some evidence of mental *defect*, the nature of which will be explained subsequently, but it was of so slight a character that it could be used only as corroborative evidence, the main reliance being placed in the disorder of conduct. It will be interesting to examine the features in the conduct of this patient which led to his being regarded as insane by a thoroughly impartial and highly intellectual layman.

The most striking feature in the case was the occurrence of the outbreaks of debauchery, accompanied by practices of sexual perversion, and in addition to the evidence of sexual perversion given at these times, when he was under the influence of drink, there was distinct evidence of a morbid tendency of this nature when he was sober. Although, as already stated, we cannot but regard the existence of sexual perversion as evidence of disorder of mind, especially when an unusually intense sexual or quasi-sexual nexus appears at a time of life at which the sexual power and sexual desire would normally be evanescent; yet it does not need the result of a recent trial to tell us that the practices of sexual perversion are of themselves regarded by legal authorities as crimes and punishable as such, and not as evidences of insanity. It was not this alone, we may be sure, which influenced the judge in coming to the conclusion that the patient was insane. Another peculiar morbid feature in the conduct of the patient was with respect to the letters of which mention has been made. Not only were these letters

of the most revolting and bestial character, not only did they contain, in writing, things which no decent-minded man would say or even think, but containing as they did evidence of crime which would have inevitably have secured his conviction had he been put, as he expected, into the dock, he yet not only posted and sent them to his associates in crime, in whose hands they became instruments for the extortion of heavy sums by way of blackmail, but he left them about recklessly where his servants or any chance caller at his house could see them and take possession of them. A man, therefore, who has committed crimes and is in dread of being punished for them, not only gratuitously and unnecessarily manufactures evidence which is enough to secure his conviction, but sends specimens of this evidence to persons, some of whom have already used it to extort blackmail from him, and leaves other specimens of it about lavishly in places where it is certain to fall into the hands of third parties. In short, he deliberately and gratuitously, without incitement or provocation or reason, does that which is calculated directly to bring upon him a result which he dreads and has reason to dread. Surely such conduct is in itself insane. We need not go behind it to discover the mental state which prompts it. The conduct itself is as sufficient evidence of insanity as is the conduct of a man who, dreading poverty, entrusts some of his property to notorious thieves, and leaves the rest of it about for anyone to take who chooses.

Another peculiarity in the conduct of this patient was his placing himself under the tutelage of the lad who has been mentioned. It was not as if he had been a man originally of weak and facile disposition or of easy, good nature. He had been a man of strong and independent character, had occupied important positions in which he had had control of large bodies of men, and had exercised this control efficiently and successfully. So far from evincing any tendency to sacrifice his own inclinations or to devote his means or his exertions to the welfare of others, he had been cold, self-enclosed, and, in fact, selfish. That such a man, of such antecedents, should place himself under the tutelage, and his means at the disposal, of a vulgar, ignorant boy, was so marked a departure from, and degradation of, his former character, that this phase of conduct was relied on, and successfully relied on, as an indication of insanity.

Then there was the further evidence of the extraordinary

voluminousness of his correspondence. It was not as if he had been always subject to incontinence of literary expressions. His literary capacity had been proved again and again, and in his position as private secretary to a Cabinet Minister he had had abundant practice in epistolary expression. Yet his letters were so extraordinarily voluminous that they were first the astonishment, then the amusement, and at last the despair, of his business correspondents. To give a single instance—in writing to an official to make a very simple request he filled 16 pages of foolscap of about 400 words each. It must be understood that there was nothing in the substance of the letter, neither in the matter nor the expression, that could be regarded as abnormal—nothing but the intolerable length.

Of course it may be said that these abnormal phases of conduct are, in themselves, evidence of disorder of mind; and I have already admitted that in insane conduct there must always be concomitant and proportionate mental disorder—that, at any rate, when conduct is insane, the motive to conduct must be insane; but none the less is it true in cases like the foregoing that the conduct is the evidence of insanity, and that, having the evidence of conduct, we have no need to inquire further.

In this case there was, in fact, some evidence of disorder of mind over and above that which was directly connected with the peculiarities of conduct that I have mentioned, but this disorder of mind, while to some extent it strengthened the case in favour of insanity, was certainly not of itself sufficient to establish that case. It was proved that the patient was emotionally unstable, that he was easily roused to furious rage, and that his rage readily melted into tears. It was proved that while his mental capacity was still quite up to the average, it was yet below the high standard that he had once attained; so that he exhibited the remarkable spectacle of a man of average, and more than average ability, who was yet a dement. Though he had lost much of his intellectual ability, yet enough remained to keep him at least up to the average, and, his mind being free from delusion, it was impossible to convince a judicial authority of his insanity upon the ground of mental defect or disorder alone.

In conclusion, the following propositions are for debate:—

- (1.) That there are cases, of which the foregoing is one, in which insanity is evinced by conduct, and cannot be established from mental disorder alone.

- (2.) That there are cases in which disorder of mind exists without insanity.
- (3.) That, therefore, insanity is not essentially a disorder of mind, nor ought insanity and unsoundness of mind to be used as convertible terms; but
- (4.) That our concept of insanity is not complete until it is understood to include, as a necessary and integral element, disorder of conduct.

Dr. BEDFORD PIERCE failed to follow Dr. Mercier in making a sharp distinction between disorder of conduct and disorder of mind. He thought the case quoted would be more correctly described as one of disorder of mind, in which the disorder was manifested by extraordinary conduct. Dr. Pierce further alluded to a patient, a clergyman, whose conduct had become quite inconsistent with his past life and the conduct of one in his position. After a careful examination, it was found impossible to sign a certificate of insanity. That the patient was insane and not responsible was quite evident from the history of his letters, yet for several months there was risk of grave scandal in his parish. Dr. Pierce suggested that in certain cases the necessity of including "facts observed at the time of the examination" in a certificate might be advantageously omitted from certificates.

*Mental Symptoms Occurring in Bodily Diseases.** By ERNEST SEPTIMUS REYNOLDS, M.D. (Lond.), M.R.C.P., Senior Physician to the Ancoats Hospital, Manchester; Physician to the Manchester Workhouse Infirmary and Lunatic Wards.

That it would be impossible for anyone in a single paper to adequately treat of the mental symptoms occurring in bodily diseases is self-evident. For it must be remembered, as Maudsley says, "that it is impossible to be out of sorts physically without being out of sorts mentally," so that the subject includes not only the slight emotional changes found in various diseases, but also the actual insanities produced by or accompanying them. All that I propose to do in this communication is to give a short account of the mental changes which I have noticed during a four years' residence in the Manchester Royal Infirmary, and during a longer experience as visiting physician to the Manchester Workhouse Infirmary, where I have charge of over 800 medical beds.

We must first investigate the *slight mental changes* accompanying disease, by which I mean those changes in the

* Read at the Annual Meeting of the British Medical Association, London, 1895.

feelings and emotions not amounting to actual certifiable insanity. These changes, as I have already said, occur to a greater or less extent in all bodily illnesses; but to describe them accurately and minutely would require the language of a Maudsley. Would that I could give more than the crudest outline of them.

We may divide these mental states roughly into pleasurable feelings, depressed feelings, and conditions of mental dulness, corresponding in actual insanity to mania, melancholia, and dementia. In addition we see marked irritability of temper and occasionally feelings of terror.

Pleasurable feelings, as might be expected, are not common accompaniments of bodily disease. They are met with in some phthisical patients, who tell you day after day, with a smiling face and bright eager eyes, how much better they are, and this even when death is imminent. Occasionally, in patients dying from various diseases, especially if there is deep religious feeling, the very act of dying is accompanied by a merciful and pleasurable feeling due to an anticipation of a freedom from suffering and an entering into a future life of bliss. The morbid condition produced by many stimulating poisons, such as alcohol, chloroform, cannabis indica, and opium, is again one of intense but transient pleasure.

Mental depression is by far the commonest slight emotional state met with in bodily disease. It may be a natural depression owing to the presence of pain, or to the fact that the person is missing opportunities or losing money from his inability to do his work; or it may be an unnatural depression, quite incommensurate with the surrounding circumstances, where there is neither bodily nor worldly distress, and even where the person knows full well that he is recovering. Depression is pre-eminently and proverbially found in abdominal diseases affecting the liver, stomach, and intestines. Curiously enough, although depression and irritability of temper were spoken of in former ages as "fits of the spleen," it is almost unknown nowadays to find mental changes in splenic disorders. In jaundice, from whatever cause, depression is most intense, and in sea-sickness it is so great that the feelings during a storm at sea have been divided into three stages—first, when you are afraid the ship will go down; secondly, when you do not care whether it goes down or not; and, thirdly, when you are afraid it will not go down. Contrary to the usual ideas, depression,

especially associated with more or less hypochondriasis, is met with in phthisis, and markedly so in my experience in the wards of a workhouse infirmary, where the *spes phthisica* is but rarely seen. Intense depression often accompanies and sometimes follows various fevers, such as rheumatism, and more particularly, as we have most of us experienced, influenza. In oxaluria and phosphaturia, either as causes or as mere accompaniments, there is often mental depression, frequently accompanied by hypochondriasis. In the interparoxysmal stages of epilepsy hypochondriasis and depression are frequently marked symptoms, the whining complaints of these patients being extremely trying to all who have to do with them. Again, after the pleasurable stage of many stimulating poisons, such as opium and cannabis indica, comes the stage of depression, and workers with carbon bisulphide have told me that in the early mornings before they have commenced work in these noxious fumes they are depressed almost to the point of suicide.

Associated with alcoholic paralysis, especially in women, there is often great depression, but in men more frequently an exalted state.

Movable kidney is very frequently accompanied by hypochondriasis; in fact, if a woman complains of vague dragging abdominal pain, and is at the same time hypochondriacal, a movable kidney should always be looked for.

Another cause of depression in women, though fortunately a rare one, is the presence of hair on the face. This depression not unfrequently passes into true melancholia or the insanity of persecution, and as the cause is so difficult to remove the outlook is not very hopeful.

Mental dulness, which must of course be distinguished from unconsciousness, is often found in bodily disease, as in various cerebral conditions, notably, in cerebral tumour, in intense headache, in phthisis, in cyanotic conditions, in disorders of the liver (such as cirrhosis and cancer), in cancer of the stomach, and as the result of various poisons. Possibly the peculiar and providential state of the majority of dying persons can be included as a form of mental dulness, for how rarely do we see actual suffering when death is approaching! The best example of mental dulness is perhaps found in myxœdema.

Irritability of temper is most frequently met with in sick children, especially at the onset and during the decline of the various fevers. It is also a prominent symptom in two

diseases of adults, namely, phthisis and diabetes, where complaints of ill-treatment, bad feeding, and bad attention are a constant trial to both doctors and nurses. It is a common feature in the gouty and those affected with various forms of dyspepsia, whether due to stomach or liver disease, and may be an accompaniment of painful conditions such as toothache or sciatica.

Feelings of terror are seen in hydrophobia and in delirium tremens, but in both these cases they are probably accompanied with hallucinations. An *appearance* of terror is generally seen both in chorea and Graves' disease, but I cannot say whether there is an actual *feeling* of terror in these two conditions.

In considering *actual insanity connected with bodily diseases*, we should not include the insanities connected with natural bodily changes, such as those of puberty, childbirth, and the climacteric and senile periods.

Insanity may occur in any of the following classes of disease:—1. Organic disease of the nervous system, whether cerebral or spinal, and here we may include Graves' diseases. 2. Disease of the heart. 3. Disease of the lungs (excluding phthisis). 4. Disease of the digestive organs. 5. Diseases of the urinary and generative organs. 6. Certain general diseases, such as gout, diabetes, and myxœdema. 7. Diseases caused by germs, including tubercle and rheumatic fever. 8. Conditions produced by various vegetable and mineral poisons. 9. Traumata, including surgical operations.

Each of these headings is sufficient to form the basis of a separate paper, and some of them the basis even of a treatise. It will be impossible for me to do more than make a few cursory remarks on each.

Insanity secondary to *organic disease of the brain* may be found in cerebral softening or hæmorrhage. It may take the form of acute mania, with noisy and incoherent raving and dirty habits; there may be melancholia even with marked suicidal tendency, or there may be simple-mindedness lapsing by degrees into the most complete dementia. Those in whom the symptoms, coming on early, are more or less maniacal, may recover from their mental affection in a few days or weeks, but there is little hope of recovery for those who gradually pass into a deeper and deeper dementia. In the majority of hemiplegics, however, the mental symptoms are much slighter than at first sight would appear.

They are very emotional, often crying, sometimes laughing without cause, they are slow in comprehension and in judgment, and the memory may be slightly impaired; but beyond this there is but slight mental change. Some years ago I had occasion to examine into the mental state of about eighty hemiplegics to test their testamentary capacity, and I found that those who had left-sided hemiplegia were almost all quite capable of making a will, and it was only amongst those with right-sided hemiplegia that I found any large proportion who were so demented as to be void of this important legal power. This is what one would have imagined *à priori* from the great importance of the left hemisphere as a speech centre.

I have on several occasions seen patients suffering merely from sensory aphasia dealt with as lunatics, but a careful distinction must be drawn between them. A person with total sensory aphasia, word blindness and word deafness, if left to himself would probably not show by his conduct the slightest sign of insanity, though he might not be capable of sustained reasoning; his emotions, feeling, and will might be normal, but his highest intellect be affected. Such cases of complete sensory aphasia are not common, however, as the condition is generally either one of word blindness or word deafness. In either case the patients may appear to the untrained observer to be insane, because from their verbal amnesia they name common articles quite wrongly, but that they know the use of such articles is easily proved. Again in word deafness they give utterly wrong answers or perform wrong actions in reply to questions and demands, but in all the ordinary actions of life they act as others would. Most of them, in fact, are quite aware of, and exactly understand, their infirmity just as much as a deaf mute does, and, as with the deaf mute, these patients are often unusually sharp and acute in observation.

In brain tumour the mental symptoms, as a rule, come on late, and are generally those of mental dulness, passing into a steadily progressive dementia. Occasionally, from an irritation of parts in the neighbourhood or from pressure of parts at a distance, there are marked hallucinations with maniacal excitement; melancholia is sometimes seen, or a mania succeeded by melancholia and dementia.

Actual insanity, associated with Graves' disease, is in my experience extremely rare. I have only seen one case in an asylum, a woman suffering from acute mania; and I have

lately seen in a nurse, suffering from commencing Graves' disease, a simple depression, passing on to marked depression, with irritability of temper and slight delusions of suspicion.

The mental symptoms of epilepsy are too well known to require further remark.

Cases of insanity connected with organic spinal disease are very rare; in fact, I have only seen them in connection with *tabes dorsalis*, in which very uncommonly typical symptoms of this disease, which have been present for months or years, are followed by general paralysis of the insane. One case of *tabes dorsalis* at present under my care used to have attacks of great excitement, accompanied with violence and shouting. These attacks we found to be due to hallucinations of hearing, the patient imagining that other patients in the wards were accusing him of all sorts of mean actions. Another case I have lately had to send to my lunatic wards, as he more or less suddenly developed marked delusions of suspicion and hallucinations of hearing. In neither of these two cases were there any signs of general paralysis of the insane.*

One occasionally meets with insanity during the progress of *valvular disease of the heart*. It is sometimes impulsive in nature, two cases of aortic disease under my care having committed suicide without any known previous mental derangement, one by jumping through a window and the other down the well of a staircase. More frequently it takes the form of delusions of suspicion and persecution, the patient saying that his food and medicine are poisoned, or that the other patients in the ward are talking about him or ill-using him. Very rarely they have ideas of grandeur, as an aortic case at present in the Manchester Workhouse, who became insane a few weeks ago, and now imagines he is the Master of the Workhouse, and that the whole place belongs to him. Personally I have not been able from the fairly numerous cases of insanity in heart disease that I have seen in the past twelve years to differentiate various forms of insanity as peculiar to various forms of heart disease, as has been done by Dr. Mickle. It is generally in the last stages of heart disease associated with difficulty of breathing, cyanosis, and dilated right heart that I have seen mental symptoms appear. Often also the mental symptoms are only

* In advanced disseminated sclerosis there may be a melancholia or a dementia, but I have only seen these conditions when the brain, as well as the cord, was affected with the disease.

present at night, the patient being perfectly normal during the day.

Apart from phthisis, mental symptoms may appear in *diseases of the lungs*, especially when the right heart is dilated, as in bronchitis and emphysema. Here again, as in heart disease, the mental troubles are more likely to develop at night. There may be delirium, hallucinations of sight, vague fears, and suicidal impulse.

I pass over insanity occurring in diseases of the digestive system, as it is so rarely seen in general hospital wards.

In the terminal stage of *gouty kidney*, instead of the usual convulsions and coma so commonly seen in large white kidney, there may appear a wild delirium, and more commonly a noisy acute mania, with possibly homicidal impulse and delusions of persecution and poisoning, the immediate friends being often the subjects of attack. Two of the most horrible death scenes I have ever witnessed were cases of this kind, in one of which the patient shouted and raved for hours against his children, using language of the most blasphemous description, and in the other accusations of ill-usage and robbery quite unfounded in character were levelled against the dearest friends.

We now must consider briefly the *diseases caused by germs*, and here we shall find a comparatively large amount of mental disease. Very rarely pneumonia is accompanied by true acute delirious mania with the wildest excitement, one case of which I have seen, the man dying about eight hours after the sudden commencement of the mania. This condition must, of course, be carefully distinguished from ordinary delirium tremens, which is so very common in the pneumonia of alcoholics. Not very unfrequently we see during the convalescence from pneumonia a melancholia with delusions of poisoning and suspicion, sometimes a dementia, these cases finally recovering in a few days or weeks. Influenza may set in with very acute mania with great excitement, delusions and hallucinations, recovery occurring as a rule. Or there may be suicidal attempts in the early stage. After influenza melancholia may occur, less frequently mania. Typhoid fever, like pneumonia, is not very rarely followed either by a stuporose demented state or by delusions of persecution and poisoning, every case I have seen ending in recovery. So far as I can remember I have never seen actual insanity accompanying or following acute rheumatism. Is it not possible that the

rarity of mental symptoms, and also of hyperpyrexia in acute rheumatism, as compared with former times, is due to an early and judicious use of salicylic acid and its compounds?*

In syphilis the mental symptoms, such as acute mania, and more commonly dementia, are probably more due to the actual gross pathological changes in the brain and its membranes, rather than to the germ itself, or to any chemical substance it may produce.

I must now consider the somewhat vexed question of phthisical insanity. I have seen, as, of course, every medical officer in a large county asylum must have seen, and especially if the asylum is old, overcrowded, badly lighted, and badly ventilated, how large a proportion of the insane die of phthisis. But let us look at the question from another point of view, and consider how many phthisical patients in a general hospital become insane. I see over five hundred cases of tuberculosis every year, and the number who become insane is very few, certainly not more than $\frac{1}{2}$ to 1 per cent. I can recall one case of acute mania in a girl with commencing phthisis, but there was marked hereditary predisposition, and the type of mania was exactly like that seen in female adolescent insanity. More commonly the insanity comes on during the long course of chronic phthisis, the patients developing delusions of suspicion and poisoning, occasionally with suicidal attempts, but the type of insanity has appeared to me to be in no wise different (except in the prognosis) from the insanity after pneumonia or typhoid fever. From my experience, then, I should say that insanity, and possibly a particular form of insanity, may predispose to phthisis, but I could not say, and do not believe, that phthisis predisposes to insanity in any more marked degree than the other fevers.

Of the many cases of *insanity caused by various poisons* I shall only mention those caused by alcohol, carbon bisulphide, and lead. Those due to alcohol are already sufficiently well known, but I would like to say a word on the peculiar loss of memory of time which is so commonly found in alcoholic paralytics. In many of these cases, in fact, the whole of the mental symptoms seem to depend on this one factor.† I have often thought it would be a comparatively

* I have lately had under my care a case of gonorrhœal rheumatism, a boy aged 18, who suddenly developed most violent mania. Mental recovery occurred in a month.

† In more marked cases there is also a total loss of memory of place, so that the patient has not the slightest idea where he is.

easy research to discover the exact seat and nature of the lesion of this loss of time memory, for in how few other mental cases do we find only a single mental factor disordered. In other cases of alcoholic paralysis we occasionally see a peculiar delusion that the patient has a child in bed, and this idea is found, not only in women, but sometimes in men.

Of late years a process of "curing" or "killing" (as it is termed by the workmen) india-rubber so as to take away its adhesive quality has been introduced in the making of macintosh garments, and in this process large quantities of carbon disulphide vapour were inhaled by the workers. I say "were," for now under better regulations the work-rooms are more thoroughly ventilated. Under the influence of the gas the workmen often became very talkative and incoherent, then had vivid hallucinations and became very excited, performing curious antics, such as turning summersaults and attempting to climb up walls. These symptoms, as a rule, gradually passed off in the open-air in a few minutes, and were followed by great depression, which only disappeared when the workmen again went into the work-rooms. In some cases the mania was lasting, and the patients were often sent to asylums quite insane. When I was Assistant Medical Officer at the Cheadle Royal Asylum eleven years ago I well remember a case of very acute and lasting mania, finally passing into dementia, occurring in a Jew. The other day I found his son under my care at the workhouse (suffering from aortic disease), and he told me that his father had been the first to introduce this process into England, and that his insanity was entirely due to the carbon bisulphide. He further added that he knew of several of the workmen who had similarly been sent to asylums from the same cause.

In the many cases of lead-poisoning which one sees in a large industrial population I can only recall three cases of insanity due to lead. One was a young girl, who had very acute symptoms with delusions of persecution, and the other two were men, who from their tremors, speech, and partial dementia at first sight resembled cases of general paralysis, excepting that they were depressed rather than elated, and, moreover, the peculiar pallor and blue line easily established a diagnosis; one recovered perfectly, the other is at present under my care.

As regards mental symptoms following closely *after*

injuries or operations, I should like to corroborate the opinion of Mr. Clinton Dent that true delirium tremens is more often diagnosed than seen. In the majority of such cases which I have seen in surgical wards there was not delirium tremens, but acute mania, often very noisy in character and associated with very vivid hallucinations of hearing and sometimes of sight. Usually the excitement is of a pleasant character, occasionally but more rarely accompanied by depression.

As a *summary* of these very discursive remarks my own experience leads me to conclude as follows:—(1) It is a comparatively rare occurrence for actual insanity to develop during the course of bodily disease. (2) In general hospitals mental disease most commonly occurs after fevers, poisons, injuries and operations, and heart disease, and perhaps in this order of frequency. (3) In the early stages of fevers, and after injuries and operations, mania is the common form of insanity, but in other conditions depression is more common, though the commonest form is an insanity with marked delusions of persecution (often associated with hallucinations of hearing), such as one sees in phthisis and heart disease and after typhoid fever. (4) There is no special form of insanity connected with special bodily disease, so that it is impossible to diagnose the bodily disease from the mental symptoms present. An exception to this is the peculiar mental condition associated with alcoholic paralysis, to which I have already alluded. (5) Insanity occurs with unusual frequency in bodily diseases associated with peripheral neuritis as in poisoning by alcohol, carbon monoxide, carbon bisulphide, and lead; pellagra, typhoid, typhus, scarlet, and rheumatic fevers, influenza, pneumonia, phthisis, syphilis, septicæmia, rheumatism, gout, and diabetes. Is it possible that in these conditions the factor which causes the changes in the peripheral nerves causes also some similar changes in the multitudinous internuncial fibres in the brain, and so produces disturbances in the normal cerebral reactions which go to make up a healthy mind? (6) Where the cause is not continuous, such as the poisons, the fevers, traumata, and operations, the mental symptoms in the great majority of cases disappear; in heart cases and phthisis they may disappear and reappear from time to time; but in some cases, such as the insanity connected with kidney disease, they only disappear with death.

*Mental Changes in Graves' Disease.** By A. MAUDE, L.R.C.P.,
Westerham.

I have nothing to say on changes of mental state due to loss of thyroid activity; the psychosis of cretinism is well defined and widely known. But I venture to think that the mental changes of exophthalmic goitre are equally defined and not perhaps as widely realized. If this be so, if there are such distinct types of mental aberration, in marked antithesis to each other, which accompany two pathological states of the thyroid, perhaps also in antithesis, this is sufficient to give the subject a place in our discussion.

In the bulky literature of Graves' disease I do not find many attempts to describe the ordinary mental condition of the patients; but we find numerous descriptions of cases which have presented definite and severe forms of mania. Such cases are naturally reported largely by pure alienists under whose charge these patients have been placed; so many histories of this class have been published that they have psychologically overshadowed ordinary cases, and might lead one to the conclusion that mania was a far commoner accompaniment than it is.

For the purpose of this paper I have taken twenty cases, with whom I am well acquainted, and with whose family histories and mental peculiarities I have been familiar for some years. The questions I wish to especially consider are the occurrence and frequency of definite insanity, and whether short of insanity there is not a typical psychical change.

We all know that acute mania and melancholia *do* occur in Graves' disease. No one has described more cases from his personal observation than Dr. Savage; we have, however, no large statistical observations of cases taken at random, from which we can draw any conclusion as to the frequency of severe mental derangement. However, Sir J. Russell Reynolds in 1890 published remarks on 49 cases. He does not mention insanity in any one, so we may fairly conclude none were insane. Of my 20 cases only one could be claimed as at all insane, and she presents a mild form of chronic dementia. I have been informed by one of the officers of one of our largest asylums that no case has

* Read at the Annual Meeting of the British Medical Association, London, 1895.

appeared there for many years. The meeting will doubtless help me on this point.

Now in a large proportion of cases of Graves' disease there is a neurotic ancestry, and I question whether the proportion of acutely insane patients is greater than it would be among other persons of such heredity who were in bad physical health. I do not propose to dwell on these cases of true insanity; there is nothing peculiar about them. When dementia occurs it is of ordinary type, usually acute, often recurrent mania, or melancholia, while delusions of persecution are very common. M. Raymond Martin, a pupil of Professor Joffroy, collected 28 published cases in 1890, and they present such varied forms of amentia that no conclusion can be drawn from them. One point is noteworthy, and has been insisted on by Hirsche, who collected 43 cases of insanity, which is that mania in any form is an occurrence of very grave prognosis; only six of his cases attained even temporary recovery. This is not surprising when we consider the cardiac and other disabilities from which these patients suffer.

Let us pass, then, to what I consider the more distinctive, though milder, form of psychosis in Graves' disease.

My 20 cases are all women, about equally divided in age between early womanhood and the sexual decline; all private patients, and a large proportion in a higher rank of society than the ordinary hospital patient. As I have said, none (or perhaps only one) could be claimed as insane, but only two present at all normal states of mind. In all but three the intellectual powers have suffered; but two of them are ladies of remarkable intelligence and a high degree of education. Both have been affected over twenty years, though in one the disease is quite quiescent. The other presents at times rather severe symptoms, but is nevertheless one of the most cultivated women I know; she is able to work as the administrative head of an important educational establishment, and (besides being an advanced student of philosophical subjects) has persevered at 48 years of age in the study of Greek and Welsh. M. Ball made the remark in 1893 that "a certain degree of intellectual and moral exaltation often exists." It is not quite clear from his description what he means by this expression, but I think if we accepted the words in their literal English translation as I have given them, that there is a good deal of truth in the remark.

The mental condition of these people is very difficult to describe, but is in its particularities very highly defined.

1. They present an extreme restlessness, resembling that which sometimes accompanies subacute mania and neurasthenia. Many of these patients are continually moving their hands and faces; again, they often have tricks of movement, habit spasms of ordinary type, such as pulling the corners of their mouths, the buttons of their dress, and so on. True chorea is frequently associated with exophthalmic goitre, but has never been present in any of my patients, and has no connection with the sort of movement habit I describe; neither is this restlessness connected with the habitual tremor of the disease.

2. Another point is the ease with which these persons are startled. A very slight interruption or noise will disturb them for hours; this is merely due to the instability of their cardiac action.

3. Sensorial illusions are occasionally present without other signs of insanity. Galezowski has described cases of hallucinations of sight, and Grainger Stewart some of hearing. I have had under observation for many years an elderly woman who has frequent illusions of hearing—thinks she hears people talking round her or calling out, but I attach no importance to this case, for it is altogether an errant one; moreover, she has some chronic eustachian catarrh with great tinnitus and vertigo, and if I were pinned down to the expression of opinion I should say had mild dementia. She is a very remarkable example of exophthalmic goitre, having once developed a train of paralytic symptoms of the basic cerebral nerves quite unique in the history of this disorder; and at another time, under the stress of alarms, a condition resembling ambulatory epilepsy.

Vertigo, even of an extreme degree, is a common symptom, and this has been found associated with recurrent mania in at least one instance. I am unable to satisfy myself that this vertigo, in its milder forms, is not due to middle ear catarrh, for I have found this condition a common one in Graves' disease.

Now we pass to what I consider the true salient mental changes.

These people become irritable, short tempered, discontented, prone to take offence at and quarrel with anything and everybody. In this they merely present the usual attributes of neurasthenics. In addition the patients become

untruthful, suspicious, and intolerant of contradiction or advice. The memory almost always becomes much impaired, especially memory of current details.

But the most distinctive mental change to my mind is that first described by Sir John Russell Reynolds, who gave it the apt name of "chorea of ideas." The patient finds it impossible to think of anything consecutively. If she makes an effort to write or talk about anything other ideas crowd into her mind and displace the original one; names and motions often in no way connected with the proper thought crop up instead of the one she wants. A patient of mine found herself unable to cut out pieces of material for needlework as she used to do, as she starts cutting out one garment and finds she has ended by trying to cut out another sort—a chemise for a skirt, and so on.

Another mental change I have seen constantly is a morbid sense of duty, an over-sensitive valuation of public opinion, or the opinion of other individuals. This is, I take it, a mild condition of melancholia, but, in my observation at least, it has never acquired the intensity of actual melancholia.

I have also endeavoured in all cases to eliminate the factor of "hysteria." The definition of this term is so vague that I have pinned my faith rather to such physical signs as localized anæsthetic patches and diminished fields of vision rather than to hysterical crises or a so-called hysterical psychosis, and I can only say that my own patients have none of them presented satisfactory signs of hysteria at all. The only physical sign which is frequently associated with hysteria, and which I have also found frequently accompanying Graves' disease, is astasia-abasia in its various forms.

I am quite aware, however, that any or even all the conditions I have described may occur in ordinary neurasthenics or hysterics, but on viewing these central nervous changes as a whole, and in fairly large numbers, I have been struck by the dissimilarity of the assembled psychic changes as compared with those of neurasthenia and hysteria. In fact, some of my patients who have presented in its most typical form the cerebral action of Graves' disease have been furthest removed from neurasthenia, and have shown none of the physical or mental attributes of hysteria.

This condition, which I have endeavoured so imperfectly to describe, stands, I think, in remarkable contrast to the apathetic mental state of myxœdema. And I have discovered

another curious little point of dissimilarity in the absence of any olfactory illusions in Graves' disease, which (you all know) are common enough in myxœdema.

So marked is this contrast that we must be led unavoidably to the inference (though we cannot yet call it a conclusion) that we have on one side a deficiency, and on the other an overplus of some material which acts as a stimulus or a toxic agent to nerve structures, and among them the nerve structures which especially concern psychologists.

*Mental States Associated with Visceral Disease in the Sane.**
By HENRY HEAD, M.A., M.D. London.

(Abstract.)

The mental changes which accompany disturbances of the viscera may be classified under two groups, as follows:—
(a) Those changes which accompany the disease directly, and are associated with the presence of some abnormal product or tissue change produced directly by the disease (for example, myxœdema). These may be called the direct mental effects of visceral disease, and will be neglected in this communication. (b) Certain mental changes which are only present in those cases where the visceral disturbance causes what is known as referred pain associated with tenderness of the superficial structure of the body and scalp. Now this pain and tenderness are due to changes in some part of the central sympathetic system caused by disturbance of the internal organ to which sensory sympathetic nerves are supplied. Thus the mental changes of this group may be said to be indirect, for they are associated with visceral disturbances through the mediation of the sympathetic system. In this communication only the sensory and emotional changes are considered.

1. The first change to which I wish to draw attention is a melancholia coming on with extreme rapidity, and lasting a variable time (from a few minutes to several hours). Under such circumstances the patient leaves the circle with all the appearance of a person leaving the room to vomit. He sits in some room apart weeping uncontrollably, without any idea of the cause of his sorrow. He may be sitting quietly

* See "Brain," 1893-4. Read at the Annual Meeting of the British Medical Association, London, 1895.

and controlling himself with difficulty when a kind word from a passer-by will set him crying with even greater ease than a sharp speech. Music is intensely disagreeable, and such people will shun any ward or place where singing or playing is going on. During these attacks the patient has an intense feeling that something ill is going to happen, but is unable to say definitely to whom or what the nature of the ill may be. It is a vague but intense feeling of impending ill which makes him write home to know if anything has happened, or leave the hospital and go home. In one case a man with phthisis was so certain something was going to happen that he wrote his name and address on a card and pinned it into his coat before leaving the workshop. All patients in this condition sit apart in some unfrequented part of the wards, and if spoken to give a short answer and then get up and go away. At the time of the attack it is exceedingly difficult to get any information from them, and one is forced to wait till the attack has passed off, or is lessening, to obtain an account of their feelings. Those patients who can visualize strongly are haunted throughout their attacks by a constantly recurring picture of their home, "dark and miserable, as if in a fog." All colours have disappeared from the room and become grey or black. There is no fire in the grate, no lamp on the table, no sunshine coming in at the window; everything is dark, dull, and dreary. But not only are the colours absent, but everything in the picture of home appears out of place; the tables and chairs are in disorder or upside down. This condition of mind may be accompanied by a distinct impulse to suicide, but the impulse is diffuse and not specialized. The reason apparently that it is so seldom acted on is the rapidity with which the emotional disturbance disappears, and the curious fact that the locomotion necessary to carry out the impulse to self-destruction tends to abolish the desire for suicide.

2. *Hallucinations.*—These may be of sight, hearing, or smell. Probably hallucinations of taste occur, but the mouth is usually in such a condition that it is impossible to be certain that the taste experienced has not an objective basis. All the hallucinations are of a low type. Those of vision consist of a figure or head, either black or white, but never markedly coloured. The figure is draped and not clothed. Intelligent patients of the lower classes have difficulty in explaining this difference, and more than one has volunteered this statement, "They are draped like

statues, not dressed in proper clothes." The faces are black, white, or frequently the head is draped "in a sheet," as the women patients usually say. The figures occasionally have long dark hair, and yet the patient is always in doubt about the sex. Sometimes the figure appears at a distance and approaches; at others it flits across the room, and out by the opposite wall. In no case are the limbs evident, except only in those rare cases where the hallucination takes the form of a hand appearing through some opening. The figure never speaks, but occasionally seems to grimace.

Hallucinations of hearing are not articulate voices. Rarely they take the form of inarticulate voices speaking together or singing "all together and out of tune," but no words are heard, and these patients never think they are spoken to, as is usual amongst the insane. Sometimes the hallucination takes the form of a bell or bells, which grow fainter, and then return, to again grow fainter. Sometimes a noise of knocking is distinctly heard, and the patient will get up three or four times to open the door, so certain is he of the knock in spite of the protests of bystanders. One man sent his wife down in the middle of the night to see why they were mending the road. Taps are heard on the outside of top storey windows.

Hallucinations of smell are much more difficult to investigate, but seem to occur with considerable frequency. Offensive drains, rotten fish, "deathly smells," burning rags or oil, escape of gas are some of the forms assumed by these hallucinations. Now, it is obvious that these are all closely akin to objective smells which may occur in a hospital, and I have therefore exercised a most rigid censorship in all cases of supposed hallucinations of smell. No hallucination has been counted unless the possibility of an external cause could be excluded, and unless the nose had been examined at the time. These hallucinations differ from smells depending on an objective cause in that they are almost always associated with nausea, and occasionally followed by vomiting. A patient may be in the middle of a meal when the hallucination occurs, and the meal is then at an end, and he is obliged to leave the table. I have seen a patient put the remainder of the supposed stinking food aside, certain from previous experience that she would be able to eat it when the smell passed off.

3. The next mental change to which I wish to call attention is a form of delusion of suspicion. These patients

fancy that their friends are against them, and when they see two people talking together they imagine that these people are talking about them. They always deny that they actually hear what is said, but they are certain all the same that they are being talked about. Just as we found that the hallucinations were of a low type, so here the delusion is broad and ill formed. They believe their friends "want to get rid of them," that "their fellow workmen want to get them sent away," that the master or mistress or superior officer think them "lazy and idle." If they think people are talking about them, it is always that they are lazy, idle, good for nothing, ought to be got rid of. Under no circumstances do they ever imagine a definite charge of fraud, impiety, or immorality, but one of laziness, idleness, physical incompetence. So vivid is this delusion, that these patients frequently accuse their friends, fellow workmen, or employers of desiring to get rid of them; but though impelled to make the charge, they have a sort of feeling that it is not true, and are ready to accept a simple denial.

4. The changes in attention, memory, and temper which occur in these patients will be treated hereafter, as the conditions under which they occur are much more complicated than those necessary for the production of the changes mentioned above.

These changes are associated with the presence of referred pain.

1. On classifying 169 cases of visceral disease of which I have complete and careful notes, we find that 87 cases suffered at one time or another from referred pain associated with superficial tenderness. Of these 87 cases 60 showed the typical depression I have described above, 31 had hallucinations during their stay in the hospital, 19 gave a history of hallucinations before admission, and 32 showed the delusion of suspicion. Of the 82 cases without referred pain or tenderness, none showed the depression, and none had hallucinations during their stay in hospital; 3 gave a history of hallucinations before admission; none showed the delusion of suspicion.

2. The mental disturbance seems to stand in direct relation to the intensity of the pain and tenderness; for if from the first group (87) we subtract 17 cases in which the scalp tenderness only occurred once during their stay in hospital,

and 8 in whom tenderness was present on the body only, 62 cases remain in which the disturbance of sensation was well marked. Of these 62 cases 59 showed the typical depression, and 3 were doubtful; 31 had hallucinations in hospital, and 15 gave a history of hallucinations before admission; 32 showed the delusion of suspicion, and 3 were doubtful. On the other hand, of the 17 cases who only showed scalp tenderness once during their stay in hospital, 1 showed the depression, none had hallucinations, 3 gave a history of hallucinations, and none showed the delusion of suspicions. Of the 8 who exhibited tenderness of the body only, none showed the depression, none had hallucinations, one gave a history of hallucinations, and none showed the delusion of suspicion.

3. Local pain, whether associated with deep tenderness or not, is not associated with these mental changes. Eight cases of pleural pain showed none of the above-mentioned mental changes. One case passed through a pleurisy without mental change, but some weeks after developed the typical mental changes in association with definite referred pain—not local, like the pleural pain—accompanied by superficial tenderness—not deep tenderness, as with the pleurisy—caused by the implication of the lung itself by the tuberculous disease. In the same way the local pain of peritonitis causes none of the mental changes I have described above.

4. The depression seems to be associated mainly with the presence of areas over the lower part of the chest and over the abdomen. The hallucinations are only present where scalp tenderness is a marked feature of the sensory disturbance.

5. The clinical conditions which lead to the development of the referred pain and tenderness in phthisis, cardiac disease, anæmia, etc., and why one case suffers from referred pain and mental changes from which another case remains free, were hastily treated before the Section, but can only be described in a full paper.

*Some Points in the Relation of Diabetes to Insanity.**

By C. HUBERT BOND, M.D., B.Sc., Pathologist and Assistant Medical Officer, London County Asylum, Banstead.

At the outset it should be stated that, if the term diabetes is to necessarily include the three cardinal symptoms—permanent glycosuria, polyuria, and thirst—the term glycosuria should be added to the title of this paper. For several of the cases upon which it is based, and which, at the request of Dr. Claye Shaw, I am about to communicate to the Association, exhibit little beyond more or less permanent glycosuria. But, inasmuch as there is no abrupt line of demarcation between classical cases of diabetes and those where one or more of the symptoms are absent, and inasmuch as it has already been pointed out by other writers that the presence of mental symptoms is apt to mask the bodily ones, and, further, since allusion will be made to a few possible cases of diabetes insipidus, it has been deemed best to adhere to the original title which appeared in the list of subjects suggested for discussion at this meeting.

That some connection exists between insanity and diabetes appears to be admitted, but their exact relationship is still uncertain. Dr. Maudsley† has drawn attention to the fact that “diabetes is a disease which often shows itself in families in which insanity prevails,” and states that the two diseases “are certainly found to run side by side, or alternately with one another, more often than can be accounted for by accidental coincidence or sequence.” It is known, too, that various nervous symptoms may develop in the course of the disease. The patient may become apathetic, morose, taciturn, and irritable, and insanity sometimes supervenes.‡ Intense anxiety and other mental disturbance, such as a paroxysm of grief or anger, are stated§ as sometimes having been definite causes of an attack of diabetes. The question of the relationship of diabetes to insanity is not a new one by any means. The subject was discussed by Dr.

* Read at the Annual Meeting of the British Medical Association, held in London, August, 1895.

† “The Pathology of Mind,” 1879, p. 113.

‡ “Theory and Practice of Medicine,” Bristowe, 7th edition.

§ “Principles and Practice of Medicine,” Fagge, 3rd edition, Vol. ii., p. 585.

Savage* before the Medical Society in 1890. His conclusions I will quote *in extenso*. They are:—"1. Diabetes might arise from local brain disease or injury, and similar conditions might give rise to insanity. 2. Similar bodily conditions might give rise to both diabetes and insanity. 3. In certain states some of the symptoms in diabetes might follow on brain changes without diabetes as a whole being developed. In other cases this might be polyuria or glycosuria. 4. In insanity, proper diabetes was uncommon. 5. Diabetes and insanity ran together in the same families, the same holding good with epilepsy, the two conditions occasionally alternating in the same individual. 6. When insanity and diabetes coincided, the insanity was usually of the melancholic type, and the symptoms of diabetes were modified by the relationship—urine might be small in quantity, or sugar absent, or no increased appetite."

Fairly numerous instances have been recorded where glycosuria has been associated with gross cerebral lesions.† But I have succeeded in coming across but few detailed descriptions of cases in which glycosuria and insanity have been associated. Dr. Savage relates‡ in detail three such cases, while Dr. Clouston has described a "Diabetic Insanity," instancing two cases of true diabetes and one of diabetes insipidus.§ The former author has stated|| that it was almost unknown for him to have a true case of diabetes among his insane. Dr. Claye Shaw tells me that previous cases which have occurred at Banstead Asylum have shown a tendency for the mental to alternate with the physical symptoms. That it is comparatively rare to meet with sugar in the urine of the insane, I would agree, provided the observations are made upon the total number of patients in our asylums, which usually includes such a large residuum of chronic demented. But limiting our observations to the urine of recent cases, I am of opinion that a larger proportion of saccharine urines would be discovered. Even among the chronic and demented patients, I think it very probable that a thorough and systematic examination of the urines would reveal sporadic cases of glycosuria in sufficient

* "Brit. Med. Journal," 1890, Vol. ii., p. 1184.

† For references to these, *vide* Tuke's "Dict. of Psychol. Med.," Vol. ii., p. 1349.

‡ "Insanity and Allied Neuroses," Savage, 2nd edition, p. 411.

§ "Mental Diseases," Clouston, 3rd edition, p. 636.

|| "Alternation of Neuroses," "Journ. Ment. Science," Vol. xxxii., p. 490.

numbers to repay the trouble entailed. To illustrate this, mention might, perhaps, be profitably made of a case in point. In February last we had twenty chronic cases transferred back to us from Nottingham Asylum; the length of time they had been under certificate ranged from six to thirty-five years. An examination was made of the urines of each, and in one instance (W. D.) I satisfied myself that sugar was present. I afterwards discovered that he was passing about 56 ozs. of urine daily, acid in reaction, sp.g. 1017, and containing glucose to the extent of $1\frac{1}{4}$ grain per ounce (the total amount of urea was 364 grains). Now there was nothing in this patient's appearance or symptoms to lead one to suspect glycosuria. He is a quiet, inoffensive man of 54, suffering from dementia, consecutive to an attack of melancholia, which came on at the age of 28. He is not a specially obese man—weight, 11 stone. He is in very fair health, but leads a completely vegetative existence. He never speaks, not even when addressed.

Certain doubts have been cast in previous investigations, as to whether in some of the cases, where reduction of the copper solution took place, an excess of lithates or some other body, not sugar, were not after all probably the real reducing agent. In the above-mentioned case and in all the following ones, in which I have suspected glycosuria, the urine has always been collected after making sure that no drug was being administered to the patient which might cause a fallacious reaction, and in every instance, before finally coming to a conclusion, the fermentation test has been resorted to.

The present investigation, carried on at Banstead Asylum, has extended over a period of 18 months. Between the 11th of January, 1894, and the 25th of June, 1895, there were (excluding transfers) 268 males admitted to the asylum; and in 175 of these an examination of the urine was made within 48 hours after admission. In 12 instances, or in 6.85 per cent. of these 175 cases, sugar was almost certainly proved to be present. The urine of these 12 patients has been tested for sugar almost daily, involving an examination of considerably over a thousand samples; and at frequent intervals—sometimes daily—the exact amount of glucose has been determined by Pavy's fluid, and corroborated by Roberts' fermentation method, where a sufficiency of glucose was present to admit of this. The following table indicates the varieties of mental disease under

which these admissions laboured, and the distribution among them of the 12 examples of glycosuria:—

Form of Mental Disorder.	Total Number of Cases.	Instances of Glycosuria on Admission.
Congenital Cases ...	2	—
Epileptic Insanity ...	18	—
General Paralysis ...	30	3
Mania	43	—
Melancholia	55	—
Delusional Insanity...	5	—
Organic Dementia ...	6	2
Senile Insanity ...	16	1
Totals ...	175	12

I will now proceed to give an account of these 12 cases, taking them in the order in which they appear in the table. I will supplement this by a description of four cases, which have occurred on the female side of the asylum within the last two years, and to which my attention was drawn by my colleagues.

CASE I. is that of T. M., aged 31. His wife states that he has always been a reserved, quiet man, and of strictly temperate habits. He was the manager of a book-shop, which position he lost, and in consequence was much worried. He became sleepless, abnormally silent, and intensely depressed. Refused to take his food and drink, and to speak. He was admitted into the asylum in June, 1894. He was dull, confused, and partly stuporose. It took him a long time to comprehend and answer questions. Physically, he was weak and emaciated. Pupils sluggish in reaction. Knee-reflex exaggerated. Palate distinctly neurotic, and he has a sister in another asylum. The urine had a sp. gr. of 1031, and contained sugar to the extent of two grains per ounce for a week after admission; the total amount voided was normal. Since then it has been free from sugar except on isolated occasions. His acute mental symptoms have all passed

off, and he is now very demented; never speaks except addressed, and then only in a listless fashion. He appears to have no delusions. There is little doubt, however, that he is a general paralytic. His speech is typical of the disease, tongue tremulous, and there are plentiful fine tremors round the mouth. All lines of facial expression have been totally wiped out. The pupils are unequal and irregular, and the knee-reflexes are rather too brisk. He has gained 23lbs. in weight. His temperature is, and always since he has been here, has been low,—97° F.

CASE II. is also an undoubted but atypical general paralytic. It is that of A. J. M., admitted into the asylum in November, 1894, aged 31. His mind had then been affected three months. A cousin of his, on the paternal side, died in Hanwell Asylum. The patient shows the neurotic taint in an extremely high and narrow palate. From the first, though excited and restless, he was more depressed than elated. He had a delusion that he was going to be burnt to death. The physical signs, however, were, and still are, typically those of general paralysis. For rather more than three weeks his urine contained sugar, from a trace, up to two grains per ounce. It was free from albumen, usually alkaline in reaction, and of a low sp. gr. (about 1010). The total amount passed was normal. Towards the end of last December he had a succession of "seizures." Since then he has rapidly been going down-hill, and has become very demented. He had a second succession last May, and a third on the 1st of last month. Since the first "seizure" the urine has remained free from sugar. His temperature is usually 0·5° below normal. He has lost rather more than a stone in weight during the last six months.

CASE III. is that of A. H. J., who was admitted in January of this year, aged 34. The diagnosis of general paralysis in this case is only provisional; but the presence of considerable lingual and facial tremor and a fairly characteristic speech is very suggestive of it, especially in the absence of any history of alcoholic excesses, which both he and his relatives entirely deny. Great depression and general apathy, with some delusions of persecution, sum up his mental condition on admission. It was said by his wife that this state had existed, on and off, for a year, and had followed upon much worry from the death of a favourite child and the accidental loss of his employment—that of a labourer. There is no other instance of insanity at all known in the family. The patient, however, had "convulsions" at teething, and has a high and narrow palate. He has a rather nervous manner. The knee-reflexes are if anything slightly exaggerated. Sugar was detected in the urine on admission, and continued for six weeks, from a trace up to 200 grains of glucose daily, the usual amount being 180 grains. During this time the patient remained very depressed, was fond of hiding away round corners; at times he

showed some tendency to be pugnacious. His depression gradually passed away, and has not returned; but there is a certain amount of mental enfeeblement noticeable. The tremors, however, remain well marked. To return to the state of the urine. Sugar was absent during the second six weeks after admission; it then was present for eleven days. It then again ceased to be detectable for nearly three weeks; it returned for four days, but has not been present from the 24th of May up to now. The sp. gr. has varied between 1010 and 1030, but quite irrespectively of the amount or presence of sugar. The reaction has always been acid. The total quantity of urine passed per diem has never exceeded 70 oz.; it is nearly always close upon 60 oz. At first his temperature remained most uniform at 97° F.; now it is 98°. No other symptoms of diabetes have been observable. He has gained 8lbs. in weight since admission.

To sum up these three cases,—two are undoubtedly general paralytics, and the third one is most probably another. They are of the melancholic and demented type. Glycosuria was present during the time their depression was most marked, and has now passed away. We have no evidence to show whether any trace of glycosuria existed prior to the existence of mental disease.

In the next six cases melancholia has been the predominant symptom.

CASE IV. was that of R. J. M., admitted on September 1st, 1894, aged 46. He had formerly been an asylum attendant, but lately a hatter. No personal or family history was obtainable. On admission he was noted to be a small spare man (weight 7st. 7lbs.). He had an anxious, careworn expression, and looked much run-down. He had a well marked *arcus senilis*. The palate was well formed and the knee-reflex normal. With very great depression there was coupled a very marked impairment of memory for all recent events. The duration of his illness given on the certificate was two weeks. The urine on admission was normal in colour, sp. g. 1015, acid in reaction, free from albumen, but contained sugar. The total amount of urine for 24 hours was estimated six days after admission, and found to be 32 oz., and contained 277 grains of glucose. For a month, during which he gained 3½ lbs. in weight, he remained mentally unchanged. He could not even remember which was his own ward. He was quite conscious of his defective memory, and showed in consequence much nervousness in manner when being questioned. During the next month his depression and confusion partly passed off. Progress was afterwards uninterrupted, and the patient was discharged recovered, after a residence of very nearly four months, having gained a stone in weight. At frequent intervals quantitative ex-

amination was made of the urine. The amount voided in 24 hours averaged 65 oz., the highest figure recorded being 96 oz. The sp. gr. ranged from 1009 to 1021, but seemed to bear no definite relation to the presence or absence of sugar. For the first month sugar was present almost daily, but in most erratic quantities, varying from a trace up to 280 grains per diem. During the second and third months a reaction was obtainable about every third or fourth day, but its intensity gradually diminished, and for three weeks before the patient's discharge the urine was free from sugar. Patient always denied all alcoholic excesses, though his memory strongly suggested such; but he stated that he had suffered much from business worries.

The chief interest in this case lies in the remarkable parallelism exhibited between the acuteness of the mental symptoms and the presence of glycosuria. This is brought out still more clearly in the following case:—

CASE V. was that of T. J. P., single, admitted on April 16th, this year, aged 57, a tobacconist. He had been well educated; had done much work at calculating figures. He had been by no means a teetotaler, but only shortly before this attack had he really drunk much to excess. His father had been insane and committed suicide when the patient was aged seven. No other member of the family was known to have been insane, nor was any instance of diabetes known of. A brother died of phthisis. For six months prior to admission the patient had gradually more and more been showing decided traits of mental derangement. He exaggerated his business worries, and became possessed of the idea that some pecuniary disaster was impending. His depression so far advanced that at times he had an inclination towards suicide. A few days before his removal he became quite excited and lost control over himself. On admission, however, he was quite calm and could give a collected account of himself. Though his memory seemed good, he was yet very confused and recognized the fact. Physically, he was a well nourished man, with a sallow complexion and rather despondent expression. The first cardiac sound was almost inaudible, the second accentuated; the beats occasionally intermitted. He had other signs of vascular degeneration in a very pronounced *arcus senilis*. Palate and knee-jerks normal. The urine on admission contained sugar to the extent of 13 grains to the ounce; and it was afterwards found that he regularly passed 45 to 50 oz. daily, acid in reaction, and free from albumen. A daily estimation of the sugar was made. It rapidly diminished from 13 to 4 grains in the ounce, and ultimately to *nil*. The sp. gr. bore a fairly constant ratio to the amount of glucose present. When this was at its maximum it was 1026; when free from sugar it was about 1012. For the first few days after admis-

sion the patient was profoundly depressed, and it was then that the sugar was at its maximum. His temperature was very low, ranging from 96.5° to 97° F. Coincidentally with his gradual improvement the sugar diminished. He gained weight, looked brighter, and in three weeks was apparently convalescent. For four days the urine had remained free from sugar, but on the 7th of May its sp. gr. rose to 1020, and it contained seven grains to the ounce. It transpired, on inquiry, that his friends had been the previous afternoon, which visit had much upset him, and caused him to become markedly depressed again. A fact such as this should not, I think, be lightly dismissed. For nearly a week the sugar ranged from four to seven grains in the ounce. He then recovered his spirits, and once again the sugar decreased to a mere trace, which remained until the 21st of May, after which date the urine remained free from it, until he was discharged recovered on June 21st.

Most curiously on that morning a good reaction was obtained to Fehling's solution. Is it possible that emotion—joy at his liberation—might have caused this? Outwardly, however, he was in no way perturbed. In this case it is again impossible to fix any date as to the onset of the glycosuria. He informed me that in the months preceding his admission he had lost three stones in weight. This fact makes one think that, at least, it is not improbable that he was passing sugar some little time before, and possibly in greater amounts than when under my observation; but he did not recall that at any time he was specially thirsty or hungry.

These last two cases are interesting in showing that the discovery of glycosuria does not necessarily imply a grave prognosis as regards mental recovery. Out of my small collection of cases, they are the only two that have as yet been discharged recovered. A study of future similar cases might possibly give us data whereby we could use the diminution in the glycosuria as an index of true mental recovery; just as we are always glad to see a melancholic fattening and putting on weight at the time that mental improvement occurs. Though it must be admitted that the presence of sugar on the day of discharge of one of these patients somewhat loosens the closeness of the connection.

CASE VI. is that of T. C., admitted May 10th this year, aged 68. I should perhaps have included him among the senile cases, but mental depression has been so prominent a symptom that I have classed him among the melancholics. There has been no other known instance of insanity in the family. His father and a brother died of phthisis. Patient has been a carpenter. For many years (since the age of 26) he has taken rather too freely of alcohol; but,

on being left a legacy, he gave up work and drank this money away during the six months before he was sent to us. On admission he was thin and haggard looking. The minute vessels of the skin over the body generally, and especially of the cheeks, were congested, walls of larger vessels hard, and the first cardiac sound was difficult to hear. There is a well-marked *arcus senilis*. The tongue was tremulous; pupils rather contracted, otherwise normal, as were also the knee-jerk and palate. He was very low-spirited and desponding; would cry to himself. His memory for recent events, too, was much impaired. He was found to be passing 108 grains of sugar daily, and at first there was a trace of albumen in the urine, which was acid in reaction, sp. gr. 1020, and was normal in amount. He has never been observed to pass more than 50 oz. per diem. A fortnight after admission the daily excretion of sugar had come down to 44 grains and then disappeared altogether, and has not been since detected except for a trace on the 10th of July. The urea has always been small in amount; has never exceeded 360 grains, but was very slightly under 300 grains when the sugar was at its maximum. His temperature at first frequently registered only 97°F., and even now seldom reaches 98°. His appetite was at first ravenous, but is now rather poor. He has never been unduly thirsty. He has gained a stone in weight. The melancholia is certainly not so marked; but, with the disappearance of glycosuria, it has by no means cleared off in the complete way it did in the two preceding instances. His memory is as bad as ever.

Though not so marked as in the previous two cases, the parallelism between the glycosuria and the mental symptoms is sufficiently seen to make the future history of this patient of great interest.

CASE VII. is that of S. H., admitted April 11th, 1894, aged 21. He comes of a very bad stock. He has one sister in Darenth Asylum, another had fits; and several uncles on the paternal side are epileptics. He has a very high and narrow palate. When first he came to us he was very melancholic, had delusions of past persecution, and many peculiar religious fancies. He believed he heard the voice of God talking to him. Traces of sugar were detected in the urine, but it soon ceased to be regularly present. After making good progress he relapsed, and developed most vivid visual hallucinations. He imagined he saw devils, and at such times became excessively violent; he evidently suffered intense terror, and would strike out at the wall or pummel himself regardless of pain. He is now rapidly passing into secondary dementia. Every few weeks, however, he breaks out into this acute state; a bout of excessive masturbation always precedes these attacks. The urine passed immediately after recovery from them used to contain sugar; lately it has not done so.

CASE VIII. is that of J. K. W., admitted February 21, this year, aged 28, single. Had been a carpenter. He is said to have been perfectly well, mentally and bodily, till three years ago, when he had influenza severely. He has never been thoroughly himself since; he became nervous, excitable, and partly depressed. Has had influenza twice since. In July last year he developed a delusion that detectives were after him. In the following October he had a very bad carbuncle; so it is possible that he has been passing sugar for a considerable time. Since last January he had been getting much more depressed. Has been a teetotaler all his life. His father's mother was insane. He himself has certain traits, Clouston's "danger-signals," of early mental breakdown, viz., a very neurotic expression; large, ungainly, almost asinine ears; a badly formed and asymmetrical cranium, the whole left side of it and of the face being smaller than the right; a deformed palate, its right half, however, being that of a normal one, while on the left side the alveolus commences much too near the mid-line. He was very melancholic on admission; was also very lost and dazed; had a distressed, but half vacant expression. It took him a long time to understand questions, and his answers were often partly incoherent; his power of attention would lapse before he got to the end of a sentence. Was constantly muttering in a low, unintelligible way. Pupils rather small, otherwise normal. Knee-reflexes somewhat too brisk. Temperature seldom above 97.1°F. Patient has remained unimproved, except that he looks a trifle better in health. Mentally he is if anything worse. He sits or stands about all day in a listless, semi-unconscious manner. Has never volunteered a coherent remark since he has been with us. Seems now hardly able to understand a question. He lost a stone in weight, but the last two months has gained 6lbs. Is addicted to masturbation. His appetite is sharp, but there is no abnormal thirst. The urine has contained sugar almost daily since admission in amounts varying from a trace to 200 grains per diem; the usual daily quantity is about 100 grains; on rare occasions it has exceeded 300 grains. The total amount of urine passed in the 24 hours varies between 40 and 48 oz. It is usually alkaline, and frequently deposits much phosphates. The sp. gr. has never exceeded 1030. Sugar has never been absent more than four days in succession. The urea excreted has never reached 400 grains.

This case is interesting in many ways, and it is a matter of great regret that we have no accurate means of saying when the glycosuria commenced.

CASE IX. is that of C. W., married, admitted June 27th, 1894, aged 37. Has been a coffee-house attendant. No insanity in family, but his father died of diabetes about the age of 60. Patient

had always been of a reserved temperament. Had an attack of adolescent acute mania 14 years ago, and was then a year in Devizes Asylum. The present attack had been coming on for three months, and he had attempted to drown himself. It had been noticed that he always became melancholic towards the end of his wife's pregnancies. On admission to Banstead he was anæmic; fairly stout; weight 9st. 9lbs.; knee-jerks too brisk; he has a normal palate. Mentally he was much depressed, but not then suicidal. Talked in a very lachrymose tone; he, however, answered queries fairly readily and to the point. He has not up to the present shown the slightest sign of improvement; has rather become worse in every way. The depression has deepened; he states it is because of the state he is in, though really he is in very fair health. He is tired of life; sees no hope in the future; would take means to destroy himself. He can occupy himself a little, but in a listless, apathetic way. He is usually sitting down, with his head bowed. Twists his hands together in a nervous manner when addressed, which he dislikes much; and now only speaks in a hardly audible whisper. His eyelids are always closed, and he looks half asleep. By no chance does he ever look one in the face. Since last May it has been known that he is greatly addicted to masturbation. It is to be feared recovery is not going to take place; he has developed the ominous habits of plucking his beard out and of swaying himself backwards and forwards in a monotonous fashion. His memory, however, remains quite good. He has a subnormal temperature, and it maintains a most even height, both morning and evening at 97° F. Pulse generally about 65 per minute. I found sugar in his urine on admission, and on no occasion since has it been absent. His bowels are generally sluggish. There has been no polydipsia or bulimia. Nor does he pass much urine; in fact rather a condition of oliguria exists; very seldom does he pass more than 35 oz. in the 24 hours, and it has fallen as low as 20 oz., while it has never exceeded 44 oz. Quantitative examination has also been very frequently made, and I find, if no preventive means are used, he daily passes between 420 and 440 grains of sugar. By dieting him and using codeia gradually up to three grains a day, the sugar can be reduced to 132 grains, but no amelioration of the mental symptoms occurs. The sp. gr. oscillates between 1025 and 1032. The reaction is always acid. When the maximum sugar is being passed the urea is 490 grains; when the sugar has been reduced it is 340 grains. He has gained weight, and he now maintains it very evenly at 10st. 3lbs.

This completes the description of the six cases, which I have classified under melancholia. But it will be remembered that in each of the three instances of general paralysis,

mental depression was pronounced, and it exists, too, as a prominent symptom in the three following patients:—

CASE X. is that of J. J. T., admitted June 19th, 1894, aged 66. Had been formerly a lawyer's clerk, and had been well educated. No other insanity in the family acknowledged. The duration of his mental breakdown was then nearly five years. The ascribed cause was shock and fright when his house caught fire. He was never the same afterwards; he became childish and showed an absolute loss of memory for all recent events. Shortly before admission he became very depressed and irritable; at times would be excited and apt to be violent. When first he came I noted him to be a well nourished man, but in impaired health. He had a difficulty in standing long, and was rather tremulous. Knee-reflexes sluggish. Palate fairly well formed. Pupils normal. The first cardiac sound was impure; vessel-wall at wrist rigid; and there was a well-marked *arcus senilis*. He was considerably depressed; emotional, would cry at the thought of the treatment he received. His memory for recent events entirely gone; he could not recall the simplest and most ordinary things. I was unable to satisfy myself that this defect dated accurately from the fright he sustained. He could remember his birthday and reckon his age correctly when told the present date. His depression has now all passed off, but otherwise he has shown no mental change whatever. He easily loses his temper, but his wrath is very transitory. He just as easily melts into tears. Impairment of gait is increasing, and the weakness is more marked on the left side. He at times tends to reel, and is dizzy. Knee-jerks and pupils are normal. He keeps at a very constant weight. His temperature is never above 98° F., but often falls to 97·5°. Pulse usually 80 per minute. The urine has never been free from sugar since admission. The amount voided averages 55 oz. daily; its extreme range is 42 to 80 oz. Sp. gr. never exceeds 1025, it is usually 1012. The amount of sugar varies from 115 to 367 grains daily. Codeia was given for several months, but has not been pushed beyond two grains a day. Its effect on the glucose excretion was practically nil. The urea has never exceeded 350 grains per day; it is generally greater when the sugar is at its minimum. There has been no increased thirst or appetite, and the bowels are regular. I have no facts at all to help me in coming to any conclusion when he first began to pass sugar. The patient's daughter states that he never was addicted to drink, but he himself acknowledges being usually "jolly" on festive occasions; and the instantaneous loss of impressions which he exhibits is strongly suggestive of past alcoholic excesses.

CASE XI. has only been with us a few weeks. It is that of S. E., married, admitted June 19th, aged 65; was a clerk. His is a post-apoplectic case of melancholia with some dementia. His

daughter states that there has been no other insanity in the family; that in March of last year her father had a "stroke," which left him somewhat physically impaired; but he remained sound mentally until last December, when he had a second stroke. He became very depressed; fancied that he was going to be shot; asked for poison; made mistakes of identity. On admission he was evidently weak; the left side of the body weaker than the right, but the right side of the face looked to be, and, from the history, was the paralysed one; deflection of tongue, however, slightly to the left side. Knee-jerks brisk. There is a partial *arcus senilis*. The heart's action is irregular; there is a double aortic murmur. Palate seems to have been narrow, but jaws are edentulous. Mentally he was very depressed, but he recognized his recent delusions as such. His memory was confused. Temperature 97° F., and remains so. The urine contained sugar and a trace of albumen. The latter was not detected again, but the former persisted until the 10th of July, since when it has not been present except once, 11 days later. The total amount of urine in 24 hours was estimated on the 3rd ult. and found to be 80oz., of a sp. gr. of 1010, very faintly acid, and contained 80 grains of sugar, but only 260 gr. of urea. There was no undue thirst or appetite, but the bowels were very costive. He is inclined to be obese. He is much more cheerful, and not so nervously anxious, but still is rather childish and distinctly mentally enfeebled. The cessation of the glycosuria was coincident with his taking a brighter view of things. It is worthy of note that when I saw the patient on the evening of the 21st ult. (the day the sugar appeared again), without my questioning him at all, he volunteered the information that on the previous day he had felt unusually low-spirited.

This case is somewhat similar to one of the three described by Savage in his "Clinical Manual." The existence of glycosuria, of course, may be a mere concurrence. But the onset of actual insanity being immediately pursuant to a gross brain-lesion, and the striking parallelism between the presence of sugar and absence of a proper sense of well-being, point, to my mind, very strongly towards a distinct reciprocal relation between the phenomena. The patient, however, has been too short a time under notice to permit of much stress being laid upon the case.

CASE XII. is an unique one in my collection. It is the only one in which I have certain evidence of diabetes existing before the mental disease, and I have the advantage of possessing full notes of the patient's illness, kindly supplied to me by Dr. Paramore. It is that of J. G., admitted May 9th this year, aged 51, married. Had been employed in a post office for very many years. Had been a man of most exemplary character and steady habits. Was

always almost hyper-conscientious. A child of his, who is now dead, was weak-minded, otherwise no actual insanity in the family, but patient has an extremely neurotic palate; in fact, it is almost deformed. Many of his relatives suffered much from gout. He himself has slightly suffered of late years. The joints between the middle and distal phalanges of all his eight fingers are enlarged, and afford good illustrations of Heberden's *nodi digitorum*. The joints of the toes and elsewhere show no outward change. Patient's mother was diabetic, and died about 50 years old of gangrene of the foot. He has probably suffered from diabetes, with all its classical symptoms, for upwards of ten years, but he did not know from what he was suffering until two-and-a-half years ago. Since then he has been under medical treatment, but would not properly carry out the instructions. Dr. Paramore thinks the diabetes has *caused* the insanity. At any rate, he brooded much over his complaint, became intensely depressed, and at last actual delusions developed. He imagined he was dishonest, that his wife and relatives had been shot, that he was to be torn to pieces. He once tried to choke himself. No alternation of symptoms occurred; that is, with the appearance of insanity the sugar in the urine did not vanish. In fact, I have reason to think its output was increased, for, having up to then been an obese man, he began to fall away rapidly. On admission he weighed 13st. 8lbs. Skin very dry and powdery. Knee-reflexes abolished; plantar and cremasteric brisk. Tongue dry, red, and cracked. Pulse 80, and feeble. Heart's action weak; first sound almost inaudible. Feet oedematous. Some half-healed boils and sores about the body. Mentally he was as above described. In addition, he exhibited a very bad memory and great confusion, and, as far as one could judge from so short an acquaintance, seemed considerably demented. For several days the urine was collected every 24 hours, and found to average 130 oz. It was very pale, acid, sp. gr. 1026 to 1033, and free from albumen, but contained sugar in amounts varying between 2,500 and considerably over 3,000, often nearly reaching 4,000 grains. Urea nearly 700 grains. He was placed on a fairly strict anti-diabetic diet, and codeia administered in gradually increasing doses. An attempt at using pancreatic extract subcutaneously was made, but was discontinued owing to a tendency to abscess formation. The output of sugar gradually fell to 500 grains daily, with no mental improvement, however; and he still lost weight. But a striking change has now occurred. Since the codeia has been increased to three grains daily the sugar has fallen to 340 grains, the urea to 504, and a very distinct mental improvement is noticed. He is much clearer, is losing his delusions; depression generally absent; has volunteered to do work; is gaining weight. Curiously, the quantity of urine, however, seems to be increasing. Only time can show whether these changes are evanescent. His temperature is nearly always 0.6° subnormal.

The four remaining cases have many features in common. They are the four females to whom I alluded early in this paper. Three are dead, one remains in the asylum.

CASE XIII. was that of E. H. Became insane at 43, but was not admitted till February 12th, 1878, eight years later. No previous history. She suffered from mania, with delusions of persecution. Became demented, but subject to brief maniacal outbreaks. The urine was not examined till very shortly before her death. It was found that she was passing 210 oz. daily, loaded with sugar; sp. gr. 1040. From the dates of notes as to her failing health and other symptoms, it is probable that this had been going on for nearly two years. No maniacal outbursts are recorded after the onset of these symptoms, otherwise there was no mental change. She was very obese up to the end, which was on December 13, 1893, after a syncopal attack. At the necropsy, 36 hours later, the following are the noteworthy points:—Skull-cap asymmetrical, correspondingly to the face. Dura mater rather too adherent. Pia-arachnoid thickened, stripped too readily. Cerebral hemispheres each weighed 19 oz., but the left looked larger than its fellow. Much atrophy in fronto-parietal region; grey matter of a dirty hue; a well-marked *état criblé* of white matter. Cerebellum weighed 5 oz.; pons Varolii and medulla 1 oz.; no naked eye abnormality. Pancreas healthy. Heart-wall was fatty, and there was aortic incompetence; liver showed fatty degeneration; kidneys granular and contracted. Unfortunately no microscopical examination was made.

CASE XIV. was that of C. S., admitted September 28th, 1887, aged 63. Her eighth attack. Age on first attack 55; alcoholism the cause. Her right leg was weaker than the left. She had hallucinations, was very maniacal and delusional. She settled down into a quiet, industrious woman, and became considerably demented. Was, however, subject to maniacal attacks at times. A year before her death diabetes was discovered, but, as she had been treated for pruritus for two years, it is likely that it existed for at least three years. Mentally she remained unchanged, but during the last four-and-half years of her life no maniacal attacks were recorded. To the last she was corpulent. She usually passed about 120 oz. of urine, containing 3,600 grains of sugar, sp. g. 1030, no albumen. Treatment much reduced this, and, when fully carried out, cured the itching and thirst. She died of phthisis last January, but her heart had long been a source of trouble to her. At the necropsy, 13 hours after death, the skull-cap was thickened. Dura mater thickened and adherent to it. Pia-arachnoid thickened, stripped too easily, its vessels very atheromatous. Cerebral hemispheres (right 18½, left 18 oz.) shrunken, convolutions atrophied, and the other outward appearances as in the last case, except for a small old softening in right optic thalamus. Lungs emphysematous, old pleural adhesions, cavity at right apex

and consolidation around. Heart large (19 oz.), aortic valve incompetent, due to atheroma. Pancreas slightly increased in size, pale, bloodless, hard, cut like cartilage in parts, duct patent. Liver $70\frac{1}{2}$ oz., fatty. Spleen $7\frac{1}{2}$ oz., very soft. Kidneys 16 oz. the pair, capsules rather too adherent, some cysts. Supra-renal capsules looked natural. The microscope revealed some cirrhosis and chronic venous congestion of the liver and kidneys, and fatty infiltration of the former; in the pancreas much fibrous formation, in parts the gland-tissue was obliterated; healthy semilunar ganglia. Sections through the right middle frontal convolution showed extensive nerve-cell degeneration, not one healthy one could be found; at the periphery were remains of a few "spider-cells" and a slight felt-work formation; no attempt at any cribriform appearances described by Dickinson, constituting the so-called "Gruyère cheese" brain. Those through the pons and medulla, however, are very cribriform. Whether the cavities correspond to Dickinson's I cannot say. Their walls are smooth, and they look to me like holes produced by the falling out of vessels; sometimes one can actually be seen alongside. The vessels were much gorged, and here and there corpuscles free in the tissue could be seen. Here again was marked degeneration in the nerve-cells, especially of the olive.

CASE XV. was very similar. It was that of M. L., transferred to us March 13th, 1890. She had an attack of mania at 44. The state of her memory suggested alcoholism. She became demented. She suffered from heart-disease and dropsy; had several syncopal attacks, one of which was fatal, after her mental affection had lasted eight years. She developed diabetes four years before death. The sugar gradually increased from 200 to nearly 3,000 grains daily. She was always corpulent. She became wet and dirty and much more demented; that, of course, might have been expected independently of the diabetes. At the necropsy, 24 hours after death, the following were the abnormalities:—Pia-arachnoid, as in last case. Cerebral hemispheres ($22\frac{1}{2}$ oz. each) much softened and atrophied; white matter had a pronounced *état criblé*. Cerebellum 5 oz., pons Varolii $\frac{3}{4}$ oz., and medulla $\frac{1}{2}$ oz.; these did not share in the general softening. Pancreas as in last case. Heart, kidneys, and liver, in appearance and weight, exactly as in last patient, except that the liver had a puckered surface and was obviously cirrhotic. Spleen 18 oz., congested. The microscope confirmed these appearances in the liver and kidneys, and showed a further fatty degeneration in the renal epithelium. Sections of the supra-renals, stained with osmic acid, showed black droplets, chiefly in their outer zone, in and around the cells. Those through the semi-lunar ganglia seemed normal. Those through the frontal convolutions and pons and medulla were precisely as in the previous case, except that the vessels of the pons and medulla were not engorged.

CASE XVI. only requires very brief notice. It is that of A. K., re-admitted here May 25th, 1894, aged 61, suffering from senile mania. She had delusions, aural hallucinations, and a very bad memory. Is now becoming quite demented. Early last June she commenced to be very thirsty and passed much urine. A specimen was examined on June 24th, and contained two grains of glucose to the ounce. It was very pale, faintly acid, sp. gr. 1003, free from albumen. The following day she became very maniacal, and has remained mildly so since. The sp. gr. of the urine fell to 1001, and there was no sugar detectable. It remained thus for several days. The sp. gr. gradually increased to 1012, and the amount of urine voided is now normal. Sugar has not again appeared.

Whether this is a case illustrative of the alternation of neuroses must be doubtful until we have had her longer under observation.

While the characteristics of some of the cases show striking analogies to each other, several differ as widely. Hence to draw up a good summary of them is not so easy. But I will endeavour, as briefly as practicable, to marshal the facts I have been able to gather, in as orderly a manner as possible.

Summary.—My instances of diabetes—perhaps I should say of glycosuria—amount, then, to 17 in number. In 12 the mental symptoms, at the time sugar was discovered, were acute; in five chronic. These five (four of whom were women) were examples of sequential dementia; in two a possible remission of some of the mental symptoms was observed with the onset of diabetes; and in one a disappearance of the latter with the accession of maniacal symptoms. But, on the whole, my cases exhibit only to a very slight degree the phenomenon of alternation. Rather the reverse is seen, namely, a parallelism between the presence and amount of glycosuria, on the one hand, and the presence and acuteness of the mental symptoms on the other. This is well illustrated in Cases IV., V., XI., and XII., and slightly in Case VI., and in the three of general paralysis. Case X. shows that this phenomenon is not without exception; for, with the disappearance of melancholia, the glycosuria has not abated. Without giving a name to the insanity from which each patient suffered, it may be said that in my 12 acute cases the prevailing feature was melancholia, and, along with this, there was in most a considerable degree of mental confusion, in some amounting to

marked amnesia. In speaking of this impairment of memory, it is noteworthy that in 14 of all my cases I was able to obtain some information as to their past habits; and in exactly half of these alcoholic excesses were revealed. The tissue-effects of alcohol as a cause of diabetes have been discussed by others; but I do not think that cases of mental disease, associated with diabetes, have had this relationship so clearly demonstrated before. In six of my cases antecedent worry* was one of the causes given of their mental breakdown. In all but one of the 12 cases some family history was forthcoming; and in six instances insanity existed in other members of the family, and seven of the patients showed personal neurotic stigmata. In two instances a parent was known to have had diabetes; and, in this connection, I might make mention of a case, now in the asylum, of adolescent mania in a girl whose father died of diabetes; her urine is free from sugar. Five cases had exaggerated knee-reflexes, one sluggish, two absent; these two were advanced cases of typical diabetes. The temperature in all 12 cases was subnormal, and sometimes considerably so; but where glycosuria ceased the temperature did not always rise. As to age, eight out of the 17 became insane at or about the climacteric. Only one was an adolescent case, with the exception of another who had an attack of adolescent mania 14 years previously. As regards sex, as before said, no systematic examination was made of the urines of the female admissions. Five of the 12 cases showed distinct signs of general vascular degeneration. The quantities of sugar, in all the cases, varied from traces to 3,940 grains. The amount of urine voided in the 24 hours was above normal in only five of the 12 acute cases. The urea, with but one exception, was always low throughout all the cases; it generally attained its chief output when the sugar was at its maximum. With regard to the two necropsies, where a microscopical examination was made, certain changes in the brain were noted; the pancreas† in both was diseased, and in each the liver and kidneys were cirrhotic.

Diabetes and psoriasis have been said to occasionally alternate.‡ I examined the urines of six patients in the

* For a good example of cessation of glycosuria on the removal of anxiety and other trouble, *vide* "B. M. J.," Oct., 1893.

† Certain possibly similar changes were described by Fleiner, under the name of arterio-sclerotic. ("Berl. Klin. Woch.," Jan., 1894).

‡ Grube, "Brit. Med. Journ.," Vol. i., 1895.

asylum, both when the psoriasis was absent and when marked, but failed to find sugar.

In conclusion, I might mention that we have four males at present in the asylum who habitually pass an excessive quantity of urine, 140, 125, 75, and 65 oz. respectively, but free from sugar. There is no evidence of their suffering from renal disease. Three are epileptics.

This paper, I fear, leaves the riddle of diabetes as far from solution as ever. It has rather been my intention to contribute further facts and cases as food for profitable discussion.

*The Surgical Treatment of Idiocy.** By G. E. SHUTTLEWORTH, B.A., M.D., Ancaster House, Richmond Hill.

The fact that considerable attention has been drawn of late years, both in the medical and lay press, to the subject of operations undertaken for the relief of idiocy and other mental deficiencies of child-life, must be my excuse for taking up the time of this section with observations resting, not alone upon my own limited experience, but largely on that of others. The operation of craniectomy, or as some prefer to call it linear craniotomy (that is the cutting out of strips of bone from the skull), has, indeed, almost passed from the domain of science to the region of romance, and articles have appeared in several of our popular magazines under such sensational titles as "Creating a Mind," which have led parents of mentally-deficient children to form extravagant conceptions of the powers of surgery in this direction. It may not, therefore, be inappropriate for medical men to weigh and measure the evidence which has accumulated during the last five years as to the possibilities and impossibilities of operative interference in these cases.

By way of illustration of the popular view of the subject, I may here quote a few lines from an article by Miss Helen Gardener in "Harper's Magazine," which, having been widely reprinted in this country, caused many anxious parents of deficient children under my charge to enquire if some good could not be done by "taking a piece of bone out of the skull to relieve pressure." The article is headed "A Wonderful Surgical Operation," and after asking its readers

* Read at the Annual Meeting of the British Medical Association, London, 1895.

"Can you think of an operation that would create a mind?" goes on as follows:—"The patient was a child about one year old, of good parentage and of healthy bodily growth, aside from the fact that its skull was that of a new-born child, and it had hardened and solidified into that shape and size. The 'soft spot' was not there, and the sutures or seams of the skull had grown fast and solid, so that the brain within was cramped and compressed by its unyielding bony covering. The body could grow—did grow—but the poor little compressed brain, the director of the intelligent and voluntary actions of the body, was kept at its first estate. Even worse than this, the struggle within its bony cage made a pressure which caused distortion, and aimless or unmeaning movement. The arm and leg turned in, in that helpless pathetic way that tells of imbecility." Then follows an account of a wonderful craniectomy, both longitudinal and transverse, by an ingenious operator, with the result that "in three days the baby showed improved intelligence. In eight days the improvement was well marked. From a creature that sat listless, deformed and unmindful of all about it, it began to take notice like other children. From an *it* it had been transformed into a *he*. . . . One month after the operation the feet and hands had straightened out and lost their jerky, aimless movements. The child is now a child. It acts and thinks like other children, laughs and coos, and makes glad the hearts of those who love it."

Turning now from the popular to the scientific side of the subject, what do we really know of the history and value of the operation, which, for simplicity's sake, I shall call *craniectomy*? First performed as long ago as 1878 (with good results on a two-year-old idiot), by Fuller, of Montreal, we hear no more of the operation until 1890, in which year cases were reported by Keen, of Philadelphia, and Lannelongue, of Paris. In 1891, Victor Horsley reported two cases to the Annual Meeting of this Association at Bournemouth, and since that date the operation has been repeatedly practised in this country, in France, and in America; less frequently, however, in more cautious Germany.

Originally the view held was that microcephalus (and its resulting idiocy) depended upon premature cranial synostosis, and, in order to release the imprisoned brain, openings in the skull, varying in form and in position—(longitudinal or transverse linear craniectomy, or *craniectomie à lambeaux*)—were made by the surgeon. In spite of the occasional oc-

currence of prematurely-closed fontanelles, careful anatomical investigation of the skulls of microcephalic idiots lends little support to the view referred to, the fact being that as a rule the skull is moulded to the brain, not the brain to the skull.

Professor Sir George Humphry, of Cambridge, has examined 19 small idiot skulls, and states that he finds nothing to suggest that deficiency in the development of the skull was the leading feature in the deformity, or that the smallness of the bony cerebral envelope exerted a compressing or dwarfing influence upon the brain (see "*Lancet*," Feb. 16, 1895, p. 425). In the case of a typical microcephalic idiot formerly under my care at the Royal Albert Asylum, who died aged 29, there was not, according to Prof. Cunningham, of Dublin, complete ossification of sutures; and in this and in several other cases of microcephalus which have been thoroughly investigated, the convolutions of the brain, such as they are, give no indication of compression, but are free, out-standing, and separated by well-marked sulci. To cut chinks in the skull, therefore, with the view of promoting brain development is, in the majority of cases of microcephalus, much as if an anxious mother were to try to improve the growth of a stunted undersized boy by cutting holes in his clothes!

The advocates of craniectomy have indeed abandoned the theory of premature synostosis as the *rationale* of the operation, and now allege, so far as I understand them, that the operation excites a sort of "alterative" effect upon the brain, promoting "conflux" of blood, and increasing cerebral pulsation. Keen, of Philadelphia, said in the course of an address to the medical officers of American Institutions for Feeble-minded Children, that "When we have an expanding brain and a resisting skull of about equal and reciprocal force, we have the normal condition in children; but if we have feeble children with poorly nourished and feebly-growing brains, in the majority of cases the feebly-growing brain cannot overcome the resistance that the normal brain can." Probably some analogous argument was used by the practitioners of trepanning in pre-historic times, for the Baron de Baye has found in the chalk of the Marne sepulchres containing numerous skulls ornamented with elliptical openings, probably made by means of a flint scraper during childhood. History, unfortunately, is silent as to the degree of brain illumination to which the men of the polished stone age attained in con-

sequence of this peculiar mode of letting in daylight through their skulls!

We can, however, criticize the modern revival of infantile trepanning in view of results recorded during recent years. In 1891, being anxious to form an opinion on the subject, I visited the clinique of M. Lannelongue at the Hôpital Trousseau. At this period there were unfortunately no craniectomized patients under treatment, but M. Lannelongue kindly informed me that of 25 cases operated on only one had died, and that the greater number of survivors were "manifestly ameliorated." This manifest amelioration I fear, however, may not have been maintained, for after four years there is no further report of the progress of these cases. M. Bourneville, Physician to the Department for Idiots and Imbeciles at the Bicêtre, indeed, refers to the subject (of which he has had ample opportunity of observation) in a clinical lecture in no very encouraging terms. "Generally speaking" (he says) "it seems to me that the surgeons have little knowledge about idiocy in its various forms. We find assigned as reasons for undertaking such an operation as craniectomy the following:—'The condition of the child is so deplorable that it seems hardly any risk to undertake any operation at all which gives a chance for relief,' whilst another remarks, 'So far as I think, it is a very lucky invention, for if we cannot help such children it is better for them to die than to live such a miserable existence.' These are surgical views *fin de siècle*, and we mention them only to condemn them. The medicine we were taught was the mission to cure, to ameliorate or to cure the sick that are entrusted to us, and not to assume the functions of an executioner." In the last published volume of *Recherches sur l'Epilepsie, l'Hystérie et l'Idiotie* (1894), Dr. Bourneville tabulates 82 cases of craniectomy; of these 14 had died, and in 31 a greater or less degree of "amelioration" had been reported. In too many cases the report of amelioration is made within a few weeks or months of the operation, and, to use the words of the writer of a judicious article in *Cassell's Yearbook for 1895*, "it appears that, as a rule, a certain amount of improvement ensues immediately after the operation, but this is not maintained, and it is quite possible that the final result of the operation is a diminution and not an enlargement in the size of the cranial cavity owing to the fact that great sclerosis and contraction take place along the lines of the wounds." In

fact Bourneville has demonstrated in three autopsies of craniectomized patients who ultimately came under care at the Bicêtre that no expansion of the cavity of the cranium is the final outcome of the operation, but on the contrary it is encroached on by exuberance of bony matter thrown out to repair the breaches made by the surgeon. He maintains that this method of treating idiocy is of little, if any, value, any apparent good results being due to increased care and attention bestowed on the child while under active observation and treatment, and not to the operation itself. So far as my own experience goes, I am quite in accord with Bourneville in the view that medico-pedagogic, rather than surgical methods, offer the best chance for the amelioration of the mentally deficient child.

Personally I am acquainted with the progress of three craniectomized patients. The after-history of two is given on page 62 by my successor at the Royal Albert Asylum, Dr. Telford-Smith. I need, consequently, only now refer to them to say that one (N. L.), who underwent a series of operations by Prof. Victor Horsley, in 1891, and again in 1894, has unfortunately not fulfilled the favourable anticipations originally formed. With regard to a third case, the child of a medical man, craniectomized (at four stages) in 1891, the father reported as follows:—"I cannot say that he has been in any way benefited by the operation. The small amount of muscular strength he had prior to that time was diminished by the operation, and he has not yet, after three years, regained it. There has been some degree of mental improvement, but probably not more than would have come had there been no operation." It is only fair, however, to add that I should not be justified in asserting that the above cases are to be taken as average samples of the results obtained from craniectomy, and I am indebted to Mr. Victor Horsley for access to his notes of other cases which certainly show a more favourable result. The improved methods of operating which experience has suggested, especially the cautious removal of small portions of bone only at one sitting, have much reduced the mortality of the operation, which was at first considerable.

Dr. Allen Starr, in his admirable work on *Brain Surgery*, devotes a chapter to the consideration of "Trephining for Imbecility due to Microcephalus;" and he divides the latter into three clinical types. The first group contains cases of hemiplegia, with or without athetosis; the second, cases of

mental defects of various grades; and the third, certain cases of sensory defects. This is no doubt an excellent division of cases appropriate for operative interference, but it seems to me that the hemiplegic cases do not necessarily fall into the category of *microcephalus*. My own view is that the designation of *microcephalus* is properly limited to a very striking and quite characteristic type of idiocy. Whilst denoting smallness of head, it is not only in size, but also in form, that it is typical. Microcephalic cases have always a narrow receding forehead, a vertex tapering towards a point, and a flattened occiput. I do not limit the term *microcephalus* to a cranial circumference not exceeding 17 inches (as has been done by some), but when the measurement considerably exceeds this, and the form of the head is quite other than I have described, it is not right to designate the case as one of *microcephalus*. Trephining is no doubt often useful in relieving pressure resulting from inflammatory products within the cranium, but it seems to me improper to describe a case of this sort under the heading of "Microcephalus treated by linear Craniectomy."

The group, first adverted to, of cases of hemiplegia, with or without athetosis, is probably one promising better results from craniectomy than do those of pure *microcephalus*. Resulting as they frequently do in children from hæmorrhage during the process of parturition, compressing the motor centres, interfering not only with movement but with speech, and so giving rise to the semblance of idiocy (though the intelligence may in truth not be much impaired), there is no doubt that the early removal of a clot, or of adventitious tissue resulting therefrom, may relieve pressure symptoms and so produce a permanent amelioration, both physical and mental. In another Section, two cases of this kind under the care of Dr. Beevor and Mr. Horsley, in which the results were satisfactory, are to be described. Similarly in cases of traumatic or localised epilepsy there is undoubtedly encouragement to trephine, supposing that the underlying organic cortical changes have not proceeded too far. But in giving a prognosis the risk of subsequent irritation by cicatricial tissue must be borne in mind.

In hydrocephalus producing imbecility there is also a fair prospect of relief to pressure, and consequent improvement, by means of Keen's method of trephining followed by drainage. The following case, chronicled by Broca, in the *Revue de Chirurgie* for January, 1891, may be taken as

typical. "A boy, four years of age, had suffered from hydrocephalus and was imbecile, and had contraction of the right arm following a series of convulsions. The trephining was done at the point indicated by Keen, three centimetres above and three centimetres behind the left auditory meatus. It was noticed that there was no pulsation of the dura, or of the brain when this was exposed. Broca punctured the ventricle with a trocar and canula, and evacuated 60 grammes of fluid; he introduced a drainage tube through the canula and allowed it to drain into gauze dressings which were changed every day or two. Pulsation returned in the brain after the operation. On the sixteenth day a very marked improvement was noticed in the child, the contracture in the right arm having disappeared. The amount of fluid drained away became progressively less, and on the fifteenth day after the operation the wound had entirely healed, and the child was discharged from the hospital very much better, physically and mentally."*

In the class of mental defect depending upon hypertrophy of brain with pressure symptoms, similar good results may be anticipated from operation, the hypertrophied brain being in this case compressed by its dural and osseous investments.

In the "*Lancet*" of July 27, 1895, there is an interesting report of a case of Jacksonian Epilepsy with Aphasia, intellectual impairment and partial hemiplegia, dependent upon inherited syphilis in a boy of 13, treated by trephining at St. Thomas' Hospital, by Mr. W. Anderson. A circle of bone, $1\frac{1}{2}$ inch in diameter, was removed on the left side from over the convolution of Broca, and the lower parts of the precentral and second frontal gyri. The dura was incised, and the cerebral pulsations, at first indistinct, quickly resumed their normal character. Three months after the operation, the boy is reported to have remained free from fits and from paralytic symptoms, but his intelligence had not greatly improved with the exception of mental irritability having been relieved. Mr. Anderson, in his remarks upon the case, observes that "It still remains to be seen whether a second operation over the precentral and frontal gyri may not be advisable with a view to influence further the still defective intellectual functions." My own impression, from what I have seen at the autopsies of imbeciles tainted with hereditary syphilis, is that brain atrophy being dependent

* Starr's "*Brain Surgery*," p. 262.

upon thickened membranes and diminution of blood supply owing to endoarteritis, it is, *a priori*, unlikely that much permanent benefit will result from operative procedures in this class of cases.

From summing up the evidence, I think we may conclude—

I. That craniectomy is but rarely (if ever) of permanent benefit in cases of ordinary congenital microcephalus, in which the original defect is in the brain, not in the bone; but that it may possibly do good, by relieving pressure symptoms and favouring brain development where premature synostosis is the result of osseous hypertrophy from constitutional causes. The diagnosis of appropriate cases is, however, beset with difficulties.

II. In recent traumatic cases, where epileptic or irritative symptoms arise from pressure, cranial operations are clearly indicated, as also they are in cases of mental impairment with hemiplegia or athetosis occurring from intra-cranial hæmorrhage during parturition—the “birth-palsies” of Dr. Gowers. The risk, however, of the cerebral defect arising from porencephalus, and not from compression by clot or false membrane, must be borne in mind.

III. In cases of mental impairment from effusion in hydrocephalus and in tubercular meningitis, tapping may be resorted to with advantage. In hypertrophy of the brain, also, trephining and section of dura mater may be beneficial in relieving undue pressure.

IV. Mr. Anderson's case (above referred to) gives expectation of, at any rate, temporary benefit by similar proceedings in cases of imbecility from inherited syphilis.

In this paper I refrain from reference to operative methods, which of late years have been constantly improving in the province of cranial surgery. Whether in the future it may be found possible to release convolutions bound down by inflammatory products and thickened membranes, so that consequent atrophy and lack of cerebral development may be modified, is a question of surgical skill and technique, upon which I am incompetent to enter; but in these days one is disposed to think that almost anything is possible to the enterprise of the surgeon.

Dr. FLETCHER BEACH said that, in his opinion, craniectomy is of no use for the relief of microcephalic idiocy. He came to this conclusion partly by reading an account of 82 cases in which the operation had been performed in “Bourneville's Recherches for 1894,” and in which very little good resulted, and partly

by observation of three cases in which the operation had been performed in the hospital with which he was connected. Apparently the authors who advocated this operation with the theory that there was premature synostosis of the cranial sutures have now abandoned that theory, as pathological anatomy has shown that the condition rarely exists, and have now been obliged to advocate the theory that the operation produces an alterative quality in the brain. In one case of idiocy that had been under his observation, craniectomy was performed no less than six times, chiefly on account of the epileptic fits from which the patient suffered. At first the fits ceased, but after the sixth operation the fits returned, and she is now under the bromide treatment. He, however, believed that craniectomy is of use in certain cases, such as result from traumatism, and hydrocephalus and hypertrophy of the brain. In the last disease he believed that the operation is of use, for in autopsies which he had made, on removing the calvaria, the brain shot up as if under pressure. He had a case of hypertrophy of the brain then under his care, in which craniectomy had been twice performed. It was early yet to say what the ultimate result will be, but, so far, the patient's eyesight has become ameliorated and the power in his legs has improved.

*Craniectomy, with the After-History of Two Cases.** By T. TELFORD-SMITH, M.A., M.D., Royal Albert Asylum, Lancaster.

(With Plates).

When Lannelongue published † his accounts of his first cases of craniectomy for microcephalus, the hope was raised that microcephalic idiocy would prove a curable form of mental deficiency, and would come to be classed among the ordinary surgical diseases of children, as being mainly a bony deformity to be remedied by the use of the knife and the saw; and though Lannelongue himself did not follow Virchow's teaching and regard premature ossification of the cranial sutures as the primary cause of microcephalus, but attributed it to its actual cause, namely, arrested development of the brain, still he considered that there was undue compression and consequent dwarfing due to bony pressure, and that craniectomy would relieve this and lead to increase of brain growth.

It seems, however, from later examinations of both microcephalic skulls, and of the brains that they contained, that the idea of pressure being exerted and acting as a dwarfing cause must be abandoned.‡

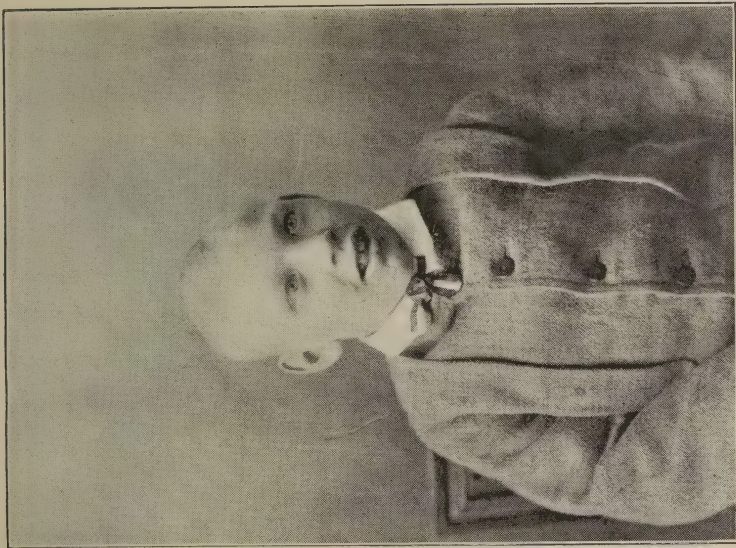
* Read at the Annual Meeting of the British Medical Association, London, 1895.

† "Congrès Français de Chirurgie," 1891, p. 80.

‡ "The Journal of Anatomy and Physiology," Jan., 1895, p. 304. "The Microcephalic or Idiot Skull, and the Macrocephalic or Hydrocephalic Skull," by Sir George Humphry. See also "The Scientific Transactions of the Royal Dublin Society," Vol. v. (Series 2): "The Brain of the Microcephalic Idiot," by D. J. Cunningham, M.D., F.R.S., and T. Telford-Smith, M.D.



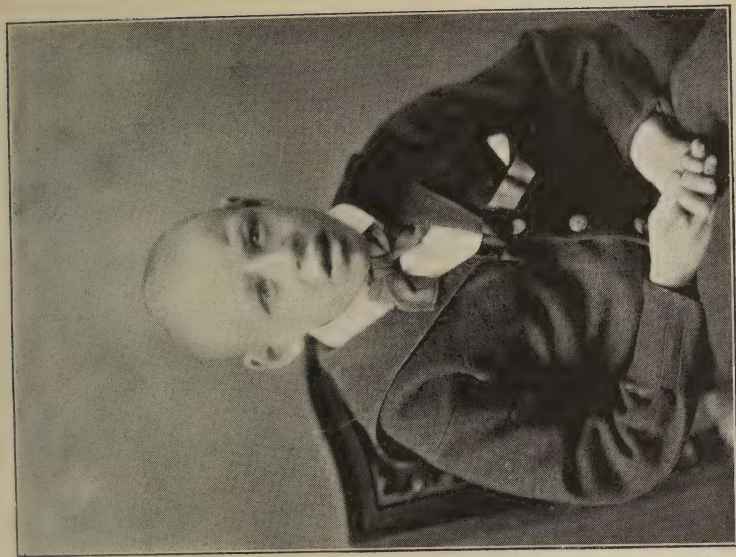
R. J. (aged 7 years).
One year before Operation.



R. J. (aged 9 years 10 months).
Eighteen months after Operation.



N. L. (aged about 18 months).
Two years before the Operations.



N. L. (aged 7 years 10 months).
Two years after the Operations.

Another point which must not be forgotten is that on post-mortem examination of cases of microcephaly in which craniectomy was performed, there is strong evidence that the after effects are rather an increase of pressure and diminution of the skull capacity than otherwise. Bourneville says: "There is a narrowing of the brain's interior by thick fibrous bands encroaching upon it," as a result of the operation.

Still the otherwise hopeless outlook as regards mental development in the case of the microcephalic idiot, even under the most favourable circumstances, doubtless rendered the operation of craniectomy justifiable as an experiment, and if it could be satisfactorily established that any hopeful mental improvement took place in the cases operated on, after even a considerable period of observation and training, the operation would have established its right to be recognized as a necessary one. Lannelongue regarded systematic training and education of the child as essential in the further treatment of the case after operation, so that to judge of the success of the surgical procedure it is only fair to wait a considerable time after the actual operation, and to observe the child continuously under suitable educational treatment. I fear that the glowing accounts given as to the results of the first cases were mainly due, as Bourneville remarks,* "to all those about the child, surgeons, students, nurses and attendants, being so interested in the child, and looking for more improvement than they did before;" when we wish for and expect a certain improvement we are very liable to imagine we see it.

The two cases whose after-history I give have had these conditions as to systematic training and education fulfilled, so that they have had all the circumstances favourable to a successful and hopeful result, and for that reason they seem fair cases from which to form an estimate as to the advisability of the operation.

I.—Both patients are boys. The first, N. L., has been under observation for four years, and under daily systematic training and education in the Royal Albert Asylum since May, 1894. N. L. (now 8 years of age) was born September, 1887, of healthy parents; he is the fifth-born child, the four older children being quite normal, mentally and physically. The

* "*Recherches cliniques et Therapeutiques sur l'Épilepsie, l'Hysterie, l'Idiotie et l'Hydrocephalie*," par Bourneville, Paris, 1894.

mother attributes the boy's condition to the fact that she had rheumatic fever during her pregnancy with him. The child was strong and active, but there was difficulty in feeding him even from his birth. His mental deficiency became more noticeable at the time he should have commenced to talk. He never has articulated more than a few simple words—ta-ta, pa-pa, bye-bye, etc. He is said to have had a kind of fit lasting five minutes when two weeks old; none since.

At the age of 3 years and 5 months, just before the operation of craniectomy was performed on him, he is thus described:—

He is strong and well-developed for his age; is extremely restless, and cannot be kept still. Constantly puts his hands to his head, and cries out as if in pain there. Knocks and slaps his head with his hands. His expression is vacant. He has to be fed; will not use a spoon. Deglutition very imperfect. Slavers. Habits very faulty; frequently wet and dirty. He is a well-marked case of microcephalic idiocy. Circumference of head, $17\frac{1}{4}$ inches.

In February, 1891, the boy was first operated on by Professor Victor Horsley. At the 59th Annual Meeting of the British Medical Association, held in Bournemouth, Prof. Horsley read a paper on "Craniectomy in Microcephaly,"* and gave an account of this boy's case up to the date of the paper, July, 1891, or five months after operation. The boy at the time of the operation was 3 years and 5 months old. A linear canoe-shaped piece of the skull, measuring about four inches long by half-an-inch broad, was removed, slightly to the left of the middle line, and extending backwards from the frontal eminence. The boy recovered rapidly and completely from the operation.

I saw the boy for the first time two months after the operation; parents say he is quieter on the whole; does not knock his head about so much, and does not cry out as if in pain.

Seen again six months after operation; somewhat less restless. Does not knock his head, nor seem to suffer from pain in the head. Some days fretful all day, and other days full of mischief. Slightly cleaner in habits.

Seen June, 1892, sixteen months after the operation.

* "The British Medical Journal," Sept, 12th, 1891, p. 579, "On Craniectomy in Microcephaly, with an account of two cases in which the operation was performed," by Victor Horsley, B.S., F.R.C.S., F.R.S.

Parents think he shows some improvement in intelligence, but not more than they would have anticipated apart from the operation. Still very restless. Speech as before. Has grown a good deal.

Second operation, Sept., 1893.—A separate longitudinal piece of bone removed close to first strip.

Third operation.—About a week later a transverse strip removed from one side of longitudinal strip.

Fourth operation.—About three weeks later a second transverse strip removed on opposite side of longitudinal strip.

Fifth operation.—About a week later another piece removed, lengthening the longitudinal strip posteriorly.

The boy recovered from each of the operations rapidly, and without any bad symptoms.

In May, 1894, he was admitted to the Royal Albert Asylum, Lancaster. At the time of his admission the only improvement that I could detect in his condition was that he had given over the violent knocking of his head, and the crying out as if in pain. He was nearly as restless as at first, and there was no change in his power of speech.

He has now been in the Royal Albert Asylum for about fourteen months, and during that time has undergone the constant and systematic training of the institution. He has been in the charge, with a few other little boys, of a bright and intelligent nurse, who has done all she can to improve his habits and develop his intelligence. He has attended school daily, and while there received the attention of the staff of female teachers, and been taught to sit in class with other children, and to give some degree of attention to what is going on in the way of musical drill and various kindergarten exercises. As a result he is now considerably less restless, and is more obedient. He seems to understand better what is said to him. His habits are somewhat improved, although he is still wet and dirty frequently. He makes a fair attempt to use a spoon in feeding himself, when carefully watched. He does not knock his head, nor cry out. On the other hand, there is no improvement in his speech; his vocabulary has not increased, and he still slavers, and he is, as far as I can see, a restless and, I fear, a hopeless case of idiocy. The only part of the improvement that seems attributable to the operation is the cessation of head-knocking; the other improvements mentioned would, I think, have taken place under training, even if the

skull had not been operated on. The boy has grown well, and continues to be physically strong and well-developed, with the full and active use of all his limbs.

				Head Measurements, N. L.			
				1891.	1892.	1894.	1895.
Circumference	...	...		17 $\frac{1}{4}$	17 $\frac{3}{8}$	17 $\frac{1}{8}$	17 $\frac{3}{8}$
Transverse	<i>a.</i>	...	..	10 $\frac{1}{2}$	10 $\frac{1}{2}$	10 $\frac{3}{8}$	10 $\frac{3}{8}$
	<i>b.</i>	...	...	4 $\frac{1}{8}$	4 $\frac{1}{8}$	4 $\frac{1}{8}$	4 $\frac{1}{8}$
Longitudinal	<i>c.</i>	...	...	10 $\frac{1}{4}$	10 $\frac{1}{2}$	10 $\frac{3}{8}$	10 $\frac{3}{8}$
	<i>d.</i>	...	...		6 $\frac{1}{16}$	6 $\frac{1}{8}$	6 $\frac{1}{4}$

Circumference taken above ears and over Occipital Tuberosity.

Transverse *a.* Tape measure from ear to ear over Vertex.

b. Calliper " " " "

Longitudinal *c.* Tape measure from Nasal Notch to Occipital Tuberosity.

d. Calliper " " " " "

Shape of Head, Dolichocephalic.

Cephalic Index, 74.5.

Measurements, N. L.			
Date.	Age.	Height. Inches.	Weight. Lbs.
1894	6 $\frac{1}{2}$	45 $\frac{1}{2}$	47
1895	8	48	49

II.—The second case, R.J., was admitted to the Royal Albert Asylum, May, 1893, at the age of 7 $\frac{1}{2}$ years. He is the first born and only child. The parents are apparently healthy and normal, physically and mentally. There is, however, a history of phthisis on both the father's and mother's side. An uncle of the father and a sister of the mother died of phthisis. There is no history of consanguineous marriage in the

family. The father was aged 26 and the mother aged 27 at the time of the boy's birth. The mother says she was in poor health during the whole period of her pregnancy. The labour was severe and prolonged; instruments had to be used, and the child was cut about the head and was asphyxiated when born. He is said to have had a fall at six months on the left side of his head and to have been unconscious for about an hour after. He has never had any kind of fit. Began to attempt to walk at about three years.

The boy is a profound case of idiocy. Cannot articulate. Slavers a great deal. Faulty in habits. Cannot feed himself. No power of attention. Is fairly developed for his age, but is not active. He walks badly, with a shuffling gait, and his grasp is feeble. Palate about normal in height and shape. Reflexes well marked. Although the boy is not markedly microcephalic (his head measuring $18\frac{7}{8}$ inches in circumference), the father seemed anxious to try the effect of craniectomy, and in January, 1894, the boy was operated on at Newcastle-on-Tyne, by Mr. Rutherford Morison, F.R.C.S.

Three discs of bone in longitudinal direction on left side of middle line removed with trephine, and the openings then united by cutting the intervening bridges of bone away with a Hey's saw.

The whole strip of bone thus removed was about five inches long by $\frac{7}{8}$ inch wide. The skull was nearly double the normal thickness, and extremely hard and dense.

The patient recovered rapidly without a bad symptom. Five months after the operation he returned to the Royal Albert Asylum. There was no apparent change in his mental condition. It is now 18 months since the operation, and during the latter 13 months of the time the boy has been under educational and general training in the asylum, in the constant charge, with others, of a careful nurse, and at intervals during the day he has come under the teaching of the school mistresses.

I cannot say that there is any improvement in either his mental or physical condition. He is still a profound idiot, without speech, and requiring everything to be done for him. He slavers as before, and his habits are still very faulty. He still walks badly and has little skilled movement in his hands. His attention cannot be fixed.

The space left in the skull after the removal of the bone

seems, as far as can be judged by pressure with the fingers, to be filling in and becoming hard.

Head Measurements, R. J.					1893.	1895.
Circumference	...	...			18 $\frac{3}{4}$	18 $\frac{1}{2}$
Transverse	a.	...	...		11 $\frac{1}{2}$	11 $\frac{1}{2}$
	b.	...	...		4 $\frac{1}{2}$	4 $\frac{1}{2}$
Longitudinal	c.	...	...		11 $\frac{1}{2}$	11 $\frac{1}{2}$
	d.	...	...		7 $\frac{3}{4}$	7 $\frac{3}{4}$

Circumference taken above ears and over Occipital Tuberosity.

Transverse a. Tape measure from ear to ear over Vertex.

b. Calliper " " " " " "

Longitudinal c. Tape measure from Nasal "Notch" to Occipital Tuberosity.

d. Calliper " " " " " "

Shape of Head, Brachycephalic.

Cephalic Index, 79.3.

July, 1895—Height, 51 inches. Weight, 64 lbs.

The operation of craniectomy for microcephalus and idiocy has now been on its trial since 1890, and taking the cases operated on in France, in America, and in this country, there are about 200 cases from which it ought to be possible to form some judgment as to the success of the operation, in so far as mental development is concerned.

The information which up to the present has been published as to the after-history of the majority of these cases is meagre in the extreme. We find in some cases "amelioration" or "improvement" reported, but particulars as to the kind and degree of improvement are not stated. Also in the published cases the space of time between the operation and the report is generally too short to admit of a well-founded opinion as to the results really due to craniectomy.

It seems time, however, to urge upon all who have had an opportunity of observing the after-results of the operation, in any cases where a sufficient time has elapsed, to publish a full and impartial account of the present condition of the patients, and to contrast it with the condition before the operation.

The weight of evidence so far is, I think, against the

operation of craniectomy, as judged not only from the facts learned from an examination of microcephalic brains, microcephalic skulls, and of skulls in which the operation has been performed, but also as judged from the actual mental and physical results obtained in even those cases where all the circumstances were favourable.

The boy N. L. may, I think, be taken as a fair test case as to the merits of the operation in microcephaly. He was in every way a favourable case to commence with, healthy and well-developed, with apparently nothing except the microcephaly to account for his mental deficiency. He has certainly had an ample amount of the bony brain case removed in the five operations he has undergone; and since operation he has had every advantage and opportunity as regards special training and education. Yet I fail to see that anything further can be attributed to the operations than the cessation of head-knocking, and though this is a distinct improvement in the boy's condition, yet it hardly seems an adequate result for the risk run. As to mental development, I see very little, and what there is would, I think, have most likely been attained by educational methods alone.

The second patient, R. J., although hardly falling into the class of microcephalic idiots, was a good test case as to the advisability of the operation in congenital idiocy. In this boy it seems impossible to see any mental improvement or sign of brain development, and I think in a similar case the operation would now rightly be considered unjustifiable.

*Voluntary Boarders in English Asylums.** By R. PERCY SMITH, M.D., Bethlem Hospital, London.

The object of this paper is to state briefly what appears to the writer to be the law as to voluntary boarders in asylums (under which term is included all English institutions for the reception of persons of unsound mind), to narrate the practice observed in such cases at Bethlem Hospital, and to gain information from those members of the Association who are engaged in the treatment of mental disease as to their practice.

It may be said without fear of contradiction that the practice of admitting to asylums and hospitals for the

* Read at Annual Meeting of the British Medical Association, London, 1895.

insane, patients who are desirous of voluntarily submitting to treatment without the formality of certification, has been a growing one of late years, and evidence of this is shown in the increased facilities for their admission to licensed houses and the increased responsibilities put upon those having the care of them in hospitals and licensed houses by the Lunacy Acts of 1890 and 1891. Whereas before the Act of 1890 a boarder could only be received for treatment in a licensed house if he had previously been under care, it is now legal, by Section 229 of the Act of 1890, for "any person who is desirous of voluntarily submitting to treatment" to be received into such an institution with the previous consent in writing of two of the Commissioners in Lunacy, or where the house is not within their immediate jurisdiction, the consent of two justices, for a specified time, upon application to them by the intending boarder, and at the expiration of that time (unless it be extended), or upon twenty-four hours' notice by the patient to the manager, he must be allowed to leave the institution. In the case of a boarder for whose admission to a licensed house not within the immediate jurisdiction of the Commissioners consent has been given by two justices, or where a boarder has been received into a registered hospital, notice of his reception must be given within twenty-four hours to the Commissioners in Lunacy (Lunacy Act, 1891, Section 20). It will be noticed at the outset that the class of patients for whose admission to licensed houses consent may be given is very wide, and includes "any person who is desirous of voluntarily submitting to treatment." As the consent, however, lies with the Commissioners in Lunacy, or the justices, it is, at any rate in the former case, likely to be withheld from those who, although acutely realising their position and desiring to be under care, yet may be certifiable, the Commissioners disliking to give consent for the voluntary admission of any person who is certifiably insane. But the wording of the clause quoted does not require that the person should not be certifiable, and it is hardly necessary in the presence of this audience to say that there are numbers of patients who are certifiable and are at the same time anxious to be placed under proper care and treatment. In the case of registered hospitals, however, the law leaves more discretion to the Medical Superintendent in the matter of admitting voluntary boarders, the previous consent of the Commissioners not being required, but there is of course the very proper pro-

vision that if the Commissioners are of opinion that the mental state of a boarder is such as to render him unfit to remain as a boarder, other arrangements shall be made. It may be well to state briefly what classes of patients from time to time apply for admission as voluntary boarders to Bethlem Hospital.

1. In the first place must be mentioned recurrent cases. Patients who have passed through an acute mental disorder from which they have recovered, and who subsequently are conscious of a return of the early symptoms of the disorder from which they previously suffered, are the most likely to wish to be put promptly under care, and it constantly happens that patients in this condition apply for admission. In many cases the attack develops rapidly, especially if the patient applies during the onset of an attack of acute mania, and it becomes necessary perhaps in a few days after admission to have certificates signed and a reception order obtained, but meantime the patient has been spared the consciousness that he is making himself conspicuous to the outside world, or the possibility of committing some act dangerous to himself or others, and his friends have been spared the intense anxiety inseparable from the early stages of an acute mental disorder.

2. Cases where there is depression which has not been noticed or has been ignored by the patient's relatives, but of which he is conscious, and which may be associated with suicidal feeling, from which the patient, wiser than his relatives, seeks protection. A good many such cases following influenza have applied for admission. In the milder varieties of melancholia, the patient is often conscious of the need for rest under medical care, and is averse to being dragged about sight-seeing or travelling.

3. Occasionally patients who have homicidal feelings, or who fear the onset of uncontrollable homicidal impulse, seek admission voluntarily. Last year a patient drove up alone in a cab to the hospital, and asked to be taken in, as he said he heard a voice telling him either to go home and kill someone or else to go to an asylum. He had hailed a cab in the street, and had said to the driver, "Drive me to an asylum." The first cabman, however, declined to take him, upon which he hailed another, who promptly brought him to Bethlem Hospital. There was no doubt that the patient fully understood his urgent need of care, having previously been in an asylum in Australia, and it would have been most

serious to refuse him admission. Within a short time other symptoms developed, and he had to be certified. Probably if he had had to apply to the Commissioners in the first place they would have refused their consent to his voluntary admission, and very likely even a short delay would have been disastrous. Eventually the patient made a good recovery.

4. It happened on one occasion that a gentleman who had had a series of epileptic fits, came alone in great anxiety and begged to be admitted, as he was sure a maniacal attack was impending. It would have been cruel to refuse admission till the attack did develop, and as he fully understood what he was doing at the time, he was admitted, subsequently to which he passed through a very short but very pronounced maniacal attack from which he recovered.

5. In some cases of general paralysis where the physical signs largely precede the mental, the patient seeks admission. I have in mind at present several cases in which there was this condition. One was a man in whose case there was a history of syphilis, and in whom convulsive seizures were the earliest indication that there was cerebral disease. He was treated for a time in Guy's Hospital, but hallucinations of hearing developed which the patient recognised were subjective symptoms, and for which his medical attendants did not feel justified in signing certificates. He was recommended to come as a voluntary boarder to Bethlem Hospital, as he quite recognised the need of being under care, and it was not till some months elapsed that the further development of physical signs and the onset of mental deterioration necessitated certification. In some other cases of general paralysis in the early stages with little or no mental deterioration, the medical attendant has refused to sign a certificate, and has recommended the patient to voluntarily place himself under care.

6. Some cases of weak-mindedness, where the patient feels that he needs the support of an asylum and is enabled to lead a more regular and healthy life under the routine and control of an institution than he would in the outer world. We have at present in Bethlem Hospital a patient of this class, who has remained voluntarily under care since 1888, paying for his maintenance, who would undoubtedly be unable to earn his living in the outside world and who would probably drift into a condition of personal neglect, and, moreover, having a small amount of means, would

easily become the prey of designing persons. The Commissioners have never been able to satisfy themselves that he is certifiable.

7. Some cases of Morphinism, Cocainism, or Alcoholism. Patients suffering from these conditions are, of course, so frequently deficient in will power that they are unable to place themselves under treatment or to resist the gratification of the craving to indulge in their favourite stimulant. With regard to alcohol, however, some patients who do wish to submit to treatment hesitate to apply to a magistrate and to consent to seclusion under the Inebriates Act in a retreat, and prefer to place themselves in a hospital for persons of unsound mind, where they are protected from alcohol without absolutely giving up all personal liberty. The defect, as far as treatment is concerned, is of course in this very fact, that they cannot be detained if they wish to leave, but in several cases voluntary detention in Bethlem Hospital has been most beneficial. In the case of a nurse who suffered from morphia and cocaine habit, voluntary detention broke the habit for a time, though her history since discharge I do not know.

8. Patients suffering from hallucinations, which they recognise to be such, and for which they wish to be under care. I have at present two patients who had this condition on admission, one of whom had previously been in the hospital under certificates.

9. One certifiable patient, whom I had at first refused to admit voluntarily on account of marked delusions of persecution, and in whose case, after certificates were signed, there was great delay in admission, caused by the difficulty in finding a justice to make a reception order, came up to the hospital and said as there was so much delay in getting the papers signed he must insist in coming in voluntarily before they were completed. He was thereupon admitted, the order and certificates subsequently arriving after a justice had been found.

10. In some cases where it has been found to be impossible to certify the patient as insane after admission, or to renew the reception order at the end of 12 months, the patient has been allowed to remain for a time as a voluntary boarder.

In one case a general paralytic had so complete a remission that it was impossible to keep him under certificates, and he was allowed to remain as a voluntary boarder, fully

understanding that he still required care. He remained thus for three years, conducting his own financial affairs and being practically a free agent, till the return of symptoms rendered it necessary to have him again placed under certificates. The case was remarkable from the long duration and completeness of the remission, as well as the total length of the illness, which from first to last covered 10 years.

11. Although we endeavour to carry out as far as possible the desire of the Commissioners that no patient shall be admitted as a voluntary boarder who is certifiably insane, yet occasionally cases arise, especially among medical men and nurses, where it is desirable, if possible, to avoid certification for the sake of the patient's future. In cases such as these, although the patient may be certifiable, I hold that it is quite legal to admit the patient if he or she understand fully the need of care in a hospital for mental diseases.

If patients who are under certificates, or even those who have been found lunatic by inquisition, are found from time to time to have sufficient mental power to dispose of their property by will, surely there are some certifiable patients who have sufficient will-power to submit voluntarily to treatment, especially if they are those who, by the nature of their profession, are best able to judge of its necessity.

Not long ago a legal Commissioner said to me that he had not to ask himself the question as to what was best for the patient, though he acknowledged that it did sometimes weigh with him, but whether he was "insane" or not and to act accordingly. The wording of the Act with regard to voluntary boarders, however, does not seem to me to necessitate such a rigid reading. It seems to me that the Commissioners err on the side of over-caution in minutely cross-examining every voluntary boarder to see whether he can, by any possibility, be put under certificates, many such patients being very undesirous of telling their whole story over again to the Commissioners, and if the latter are convinced that the patient is really a voluntary one, and not detained against his will without certificates, it ought to suffice.

Certain difficulties are met with in regard to the admission and treatment of voluntary boarders.

In the first place patients are sometimes sent up by medical men as uncertifiable and fit for voluntary admission who are seen to be after very short conversation easily certifiable and quite unfit to come voluntarily, and these it is of course necessary to reject till the law is complied with, and it is necessary for medical practitioners to understand that the question of fitness for voluntary admission must be finally decided by the Medical Superintendent.

I always make a practice of asking the patient if he understands that he is coming to a hospital where mental diseases are treated, and where there are other patients suffering from the same condition, and it seems to me quite indefensible to disguise the fact till the patient finds it out after admission, and it is equally indefensible to admit as voluntary boarders patients who are so weak-minded that they will consent to anything or sign anything that is put before them. Every voluntary boarder admitted to Bethlem Hospital signs an agreement to conform to the rules of the hospital, and to leave the hospital when called upon to do so by the Governors or Resident Physician, and the relatives sign an undertaking to remove the patient or take the necessary steps for his care immediately notice is given them. This agreement is stamped, and, of course, enables us to get rid of an objectionable boarder, and to obviate the possibility of having a patient left on our hands with no one to be responsible in the event of difficulties arising. The Committee see every boarder at their next meeting after his admission, and ask the question whether he is willing to remain, and if not the friends are instructed to remove him forthwith. In the event of the friends of a voluntary boarder who becomes certifiable failing to act, or in the case of a friendless voluntary boarder who becomes certifiable, the only course is to invoke the aid of the parish authorities.

If the necessity for certification arises, in many cases this has to be done without the removal of the patient first, but in some cases, if practicable, it is undoubtedly desirable to send the patient out in the care of his friends for the necessary formalities to be gone through. In all cases where a voluntary boarder has to be certified without being first removed, it seems right to give the patient notice of right to see a justice if he has not been seen by one before the reception order has been made.

It is possible, now that there are such facilities for the

admission of voluntary boarders to asylums and hospitals, that some individuals may simulate the milder forms of mental disorder in order to avail themselves of the comforts of an asylum, in spite of the deprivation of liberty involved to a certain extent in all cases. This may be to some extent guarded against by regarding every voluntary boarder (I speak, of course, only of those admitted for treatment, and not of the friends of patients) as a "case" in the same way as a certified patient—that is to say, that the history should be as carefully taken from the relatives, the patient's state on admission should be as carefully gone into, and notes of his progress should be kept in a case book just as in other cases. Possibly the likelihood of this form of malingering may account for the absence of any arrangement for the admission of voluntary boarders to county asylums, but that there are genuine cases of the milder mental disorders in the poorer classes in which at present the patient has to go practically untreated till he becomes bad enough for certification will not, I think, be contradicted, and it is worth consideration whether some provision for cases of this nature should not be made.

In presenting these few remarks I may be thought, perhaps, to have merely given utterance to truisms, but it seems to be desirable that some agreement should be come to among those practising in mental diseases as to the nature of the cases suitable for treatment as voluntary patients, and as to the mode of dealing with them.

*The Law of England in Relation to Single Patients.** By L. A. WEATHERLY, M.D., Bailbrook House, Bath.

Law is often, I fear, somewhat unsatisfactory. In no class of cases is it more so than in those in which it attempts to carry out the clauses of the last Lunacy Act relating to single patients.

I take it that this Act and all Lunacy Acts have two common objects in view —

1st. To protect the liberty of the subject, to see that no person whose insanity is not clearly proved shall have his liberty taken away.

* Read at the Annual Meeting of the British Medical Association, London, 1895.

2nd. To supervise the care and treatment of those who have been proved to be fit and proper persons for treatment as insane individuals.

The general public are for ever clamouring that the law to carry out these objects should be made more and more stringent.

That this general public in its said clamouring is most illogical is proved by the position it takes up with regard to "single patients."

It is this same general public who place their insantly afflicted relatives in single care in the houses of Dick, Tom, or Harry, Martha, Mary, or Jane, without allowing them to say one word as to whether or no they agree to such treatment, without certification or magisterial order, and without any possible supervision of whatever treatment they may have to undergo; and yet who are ready, if prosecution should follow, to stand up and declare that their relatives, thus illegally incarcerated, are not insane, and were not so placed for care and treatment as persons of unsound mind.

If not insane, for what have they had their liberty taken from them? for what is so much a week or so much a month paid? for what reason is it that they cannot be treated in their own homes?

Section 315 of the Lunacy Act reads thus:—

1. Every person who, *except under the provisions* of this Act, receives or detains a lunatic or alleged lunatic, in an institution for lunatics, or for payment takes charge of, receives to board or lodge, or detains a lunatic or alleged lunatic in an unlicensed house, shall be guilty of a misdemeanour, and in the latter case shall also be liable to a penalty not exceeding fifty pounds.

2. Except under the provisions of this Act, it shall not be lawful for any person to receive or detain two or more lunatics in any house, unless the house is an institution for lunatics or workhouse.

3. Any person who receives or detains two or more lunatics in any house, except as aforesaid, shall be guilty of a misdemeanour.

This is the law then, which has been created not by one or two individuals, but as a result of public opinion and public desire.

Why is it not carried out? Why do prosecutions under

these clauses continually fail? If official supervision, stringent rules and regulations are insisted on in institutions which are supposed to be governed by competent and experienced persons, and in which it is almost impossible that anything deleterious to the patient can be done without coming to light, how much more so must it be necessary that single care of insane folk should come under official inspection and be carried out under definite rules and regulations.

When some years ago I stood forward as an earnest advocate of this mode of treatment in certain cases I maintained in the most forcible manner possible that it was a form of treatment which should be recognised, but most undoubtedly should be *properly supervised*.

That the single care of insane cases is rapidly increasing admits of no contradiction; that it is more and more less subject to supervision is equally true; and I cannot but think that the Legislature will soon have to carefully consider some mode of dealing with the utter want of recognition by a law which it has, after careful consideration, framed for the protection of the insane.

Not only is the system of placing single cases of insanity in private houses without certification, and its consequent supervision becoming more and more general, but we have now constantly brought before our notice unlicensed houses in which several persons of unsound mind are boarded in direct violation of the law; and to such a pass has failure of the prosecution in these cases arrived, that I believe it is an open secret that "the authorities that be" have given out that they do not intend to bother themselves any more about such defiance of the law.

Can the public reconcile their insistence upon stringent laws, and hard and fast rules and regulations, with their apparent perfect satisfaction with these modes of care and treatment, carried out under no rule, no regulation, and utterly without anything like adequate supervision?

But you will ask, and rightly ask, what do you propose should be done to mitigate the possible evils of this increasing system of treatment?

Gentlemen, this is what I hope to get more clearly elicited by discussion, but I may say that, after some lengthened experience, I would humbly put forward some such abstract suggestions as follow:—

1st. Educate the public to recognise that insanity is no

crime, but a disease; that it is nothing to be ashamed of; that it need not even be classed with the drunkard's liver, the soaker's granular kidney, or the *roué's* syphilitic laryngitis, and that the certification of insanity does not in any way mean publicity.

2nd. In those cases in which certification may be difficult, that it should be insisted upon; that a report be sent to the authorities stating that So-and-so has been placed in a certain house of care and treatment, but that the unsoundness of mind is not sufficient to admit of certificates being signed.

3rd. To admit of proper supervision of all these cases that district officials be appointed to act, as it were, as Deputy-Commissioners.

With the ever-increasing number of lunatics to be visited, it is becoming more and more apparent that the present Board of Commissioners must be enlarged, and I fully believe that when that time comes it will be found that the appointment of District Inspectors will be the means by which its official work will most adequately be done.

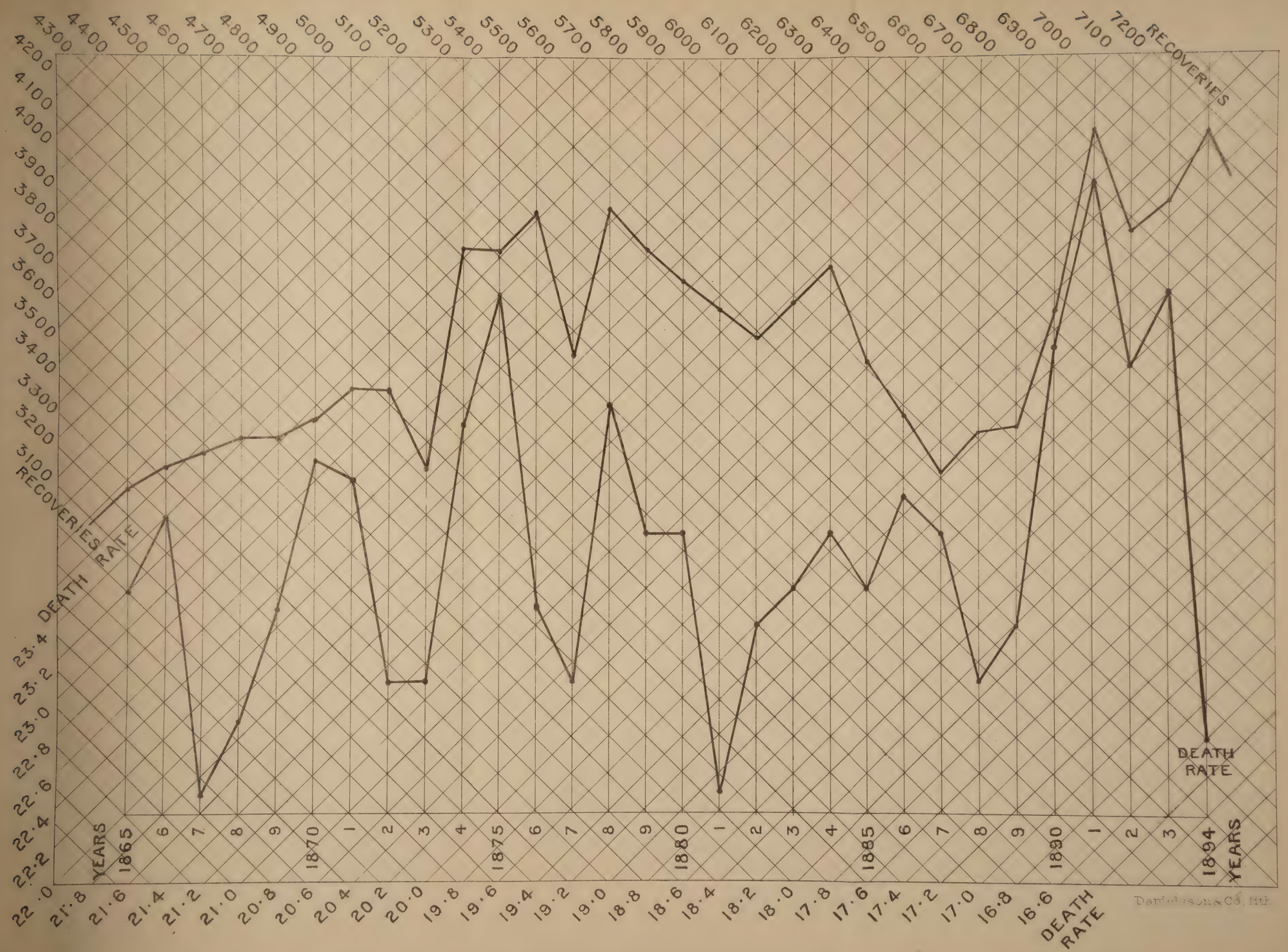
If it were possible in England to carry out such a plan as this, we should then have as a most useful adjunct to asylum care a recognised, legal, and properly-supervised mode of dealing with many of our insane population, and a form of treatment capable of wide extension, and possibly of much good. I place these suggestions on record as being eminently practical, for everyday experience of similar provisions under the Scottish Lunacy Acts has proved my case up to the hilt.

Dr HAYES NEWINGTON said that the chief difficulty in enforcing the law in regard to the points raised by Dr. Weatherly arose in the legal mind. As in other respects, the law was plain enough but the interpretation was various. A case occurred lately in which the following question was left to the jury—"Did So-and-so receive a patient for treatment in the same manner as patients are treated in asylums?" It must be regretted that the further question was not at once asked, "What is the difference between the treatment of any particular case in a private house and that which the same individual would receive in an asylum?" It must be assumed that in the former would be provided safeguards, adequate nursing, and skilled medical supervision. No asylum physician would desire to provide more or less.

Insanity is Decreasing: A Statistical Item Suggesting that.

By T. A. CHAPMAN, M.D., County Asylum, Hereford.

It has always appeared to me that the various figures that are supposed to indicate an increase of insanity are not only inconclusive, but do not really show anything of the sort, and that there are even some vague and indefinite indications that there is really a decrease in the annual production of insanity. Some years ago I tried to find some figures amongst the various statistics we possess that would throw some light on this point, but practically without success. It seemed that such increase in the annual admissions to asylums as was beyond that due to increase of population was more than accounted for by slighter (*i.e.*, less demonstrative) cases of acute insanity and various forms of chronic, senile, and degenerative disorders being yearly sent to asylums more freely, but I could get no figures proving this. A somewhat suggestive fact in this direction is the often-made remark that acute mania is less abundant, melancholia more so than formerly; acute mania of an active (*i.e.*, demonstrative) type was always sent to asylums pretty well up to its actual amount. Melancholia used to be very largely left at home or treated in workhouses. But where shall we find such facts embodied in figures. Acute mania of our statistics includes the milder as well as the more demonstrative cases, and so shows an increase just as the total figures do. There are, then, so far as I know, no figures showing the real annual occurrence of insanity that are comparable year by year. There are, indeed, no figures that give the actual annual production of insanity apart from chronic and recurrent cases. There are no figures of any definite form and intensity of acute insanity. True the Commissioners' Reports give us statistics of general paralysis, but this is precisely the one form of acute insanity that is not an insanity; that is, it belongs to a different natural order of diseases from the other diseases we mean by insanity. I have elsewhere stated that this always appears clearly on a comparison of the statistics of general paralysis with those of insanity proper, and the same opinion has been expressed by authorities who have approached the matter from a pathological and therapeutical standpoint. Its remarkable geographical distribution and its specially urban character



To illustrate Dr Chapman's paper.

equally show it to be different from the other insanities, which have no similar features. That this disease is increasing owing to the more and more urban character of our population affords no ground for assuming a similar progress in the true insanities. The annual recoveries must, however, be largely dependent on, and proportional to, the annually occurring cases, but will, of course, so regarded, be vitiated by the increase of population and by the increased admissions of milder forms of insanity and by the recoveries of recurrent cases.

Still, the former will be, roughly, an increment of fairly uniform proportion year by year, and the latter will also be an addition increasing year by year, not dissimilarly to the underlying figure we want to know.

We should have, then, in the annual recoveries a figure that would contain the one we want, but would contain it so overlaid by other additions that its actual amount would be altogether unascertainable. But supposing our figure to fluctuate year by year, then it seems tolerably certain that the annual number of recoveries will similarly fluctuate, though these fluctuations may be somewhat obscured by fluctuation of the added figures due to other causes, *i.e.*, in some years there may have been a greater or lesser tendency to increase the proportion of milder forms of insanity that are added to and obscure our figures. The annual admissions would certainly (and do) fluctuate in a similar manner, but would be more overlaid by fluctuations in chronic cases. The admissions in Class I. of the seventh Table of the Tables of the Association would probably be an even better figure than the recoveries, but they are not available. They are not given by all asylums, and were less frequently given some years back; so that the question of the labour of collating them does not arise.

We come back, then, to the annual recoveries as a not very accurate, but still probably useful series of figures, showing not the actual figures of annually occurring insanity, but some of its fluctuations. Can we make any use of them in the direction of showing a possible increase or decrease of the main figure itself?

It has always seemed to me that though we are provided with lists of causes of insanity, divided into predisposing, exciting, and so forth, that these are all (if we except heredity), and especially those that are the most effective, precisely the causes of most other forms of disease, from

which it would follow that the sanitary progress of the last quarter of a century ought to have diminished the production of insanity, as of many other diseases, and that therefore fluctuation in the annual production of insanity, the only available figure, as we have just seen, ought to be parallel to the fluctuation in the general health of the community. The annual death-rate as returned by the Registrar-General is acknowledged to be a good measure of this.

I compare, then, the annual recoveries in all asylums, etc., in England and Wales for the past thirty years, and the annual death-rate for England and Wales during the same period.

The former is a gradually increasing figure, the latter a gradually diminishing one. To compare them I have made them parallel in the annexed diagram by laying off the abscissæ on opposed diagonal lines. On making this comparison parallel fluctuations are very apparent—sometimes remarkably and strikingly evident, at other points less so—but the parallelism fails less frequently and to a smaller degree than the imperfection inherent in the figures would have led us to expect.

It is especially remarkable that since I first put these figures together some years ago, the epidemics of influenza of recent years have produced a rise in both the recoveries from insanity and the general death-rate that is, perhaps, the most pronounced of the series.

Any cause influencing the general health of the community will produce its effects on both series of figures, after a definite interval, and probably in all cases the death-rate will be increased at an earlier date than the number of recoveries from insanity.

This will certainly, at any rate, be the case when influenza is the cause in question. It produces a very immediate effect on the death-rate, but the insanity follows at some interval, and the recovery at a still longer one.

This probably explains why the extraordinary fall in the death-rate in 1894 is not accompanied by a corresponding fall in the recoveries, but I venture to predict that this fall will be reflected in the recovery curve, in the figures for 1895, for which the actual number of recoveries will probably be as low as 6,700—a prediction that may be falsified should 1895 itself have any unusual influence on the figures.

Annual Death-rates for England and Wales, and Total Number of Recoveries recorded in all asylums for England and Wales for the years 1865 to 1894 inclusive.

Years.	Death-rate.	Lunacy Recoveries.
1865	23·2	3,290
1866	23·4	3,439
1867	21·7	3,581
1868	21·9	3,707
1869	22·3	3,801
1870	22·9	3,968
1871	22·6	4,151
1872	21·3	4,246
1873	21·1	4,144
1874	22·3	4,828
1875	22·8	4,909
1876	20·9	5,106
1877	20·3	4,842
1878	21·6	5,332
1879	20·7	5,310
1880	20·5	5,338
1881	18·9	5,366
1882	19·6	5,372
1883	19·6	5,574
1884	19·7	5,775
1885	19·2	5,610
1886	19·5	5,587
1887	19·1	5,513
1888	18·1	5,721
1889	18·2	5,841
1890	19·5	6,250
1891	20·2	6,846
1892	19·0	6,670
1893	19·2	6,853
1894	16·6	7,130

On examining this diagram in more detail, we note in the first place, as having the most direct bearing on our present subject, that there are high points on both lines at these dates :—

Death-rates ...	1870-71 ...	1874-75	... 1878 ...	1884 ...	1890-91 ...	1893
Recoveries ...	1871-72 ...	1874-75-76	... 1878 ...	1884 ...	1890-91 ...	1893

Low points on both series in

Death-rates ...	1872-73 ...	1876-77	... 1881 ...	1887-88-89 ...	1892
Recoveries ...	1873	... 1877	... 1882 ...	1887-88-89 ...	1892

The only position in which there is any serious deviation from this rule of correspondence is that the fall in the death-rate in 1867 has no corresponding movement in the recoveries; there is also a want of correspondence in the movements between 1884 and 1887, but this is really an evidence of agreement rather than a discrepancy when we note that a decline in the death-rate lags behind when we come to the recoveries, so that the zig-zag here in the death-rate would be apt to produce a smoother line in the recoveries.

There is another large want of correspondence in the two series of figures, which illustrates the difficulties of many statistical inquiries in lunacy matters. This is the large space between the two lines from 1875 to 1886. This does not override the fluctuations, but it prevents a close correspondence in their amplitudes. I think there is little doubt that the 4s. grant is here responsible for the increase in the recoveries, but I do not think the approach of the figures in 1886 means that its effect is exhausted by that time. More probably it means that in making the two series of figures parallel, I have rather unduly depressed this forward end of the recovery curve.

There is thus so great a correspondence between the recovery curve and that of the general death-rate, in general form, as to give a strong confirmation to the hypothesis that led us to search for it, viz., that if we could get it by itself, unalloyed by annually increasing additions of milder and chronic cases, we should find the figure representing the annual production of insanity, when corrected for increase of population, to be a figure not only fluctuating, but also diminishing, *pari passu* with the annual death-rate.

In the period under record, the death-rate has fallen from 23·4 per 1,000 to 16·6, or about 30 per cent.

I entertain no doubt, though I hardly expect to carry with me those who have not paid more or less continuous attention to various sides of lunacy statistics, that there has been a parallel, if not so great, diminution in the actual production of insanity annually, and I doubt very much whether other causes have in any material degree counter-balanced this; if they have, it remains true that a large diminution has been produced by sanitary progress, without which these other causes, if they exist, would have been still more effective.

I would express my conclusion most definitely, perhaps, if put in this form. The average man is now less liable to insanity than he was 30 years ago to some degree, not exceeding 30 per cent. He is, however, more liable to be sent to an asylum, because he will now be sent for reasons that would not have led to that result 30 years ago.

I do not claim that such decrease of insanity is actually proved by these figures, still less that it has occurred to the extent mentioned, but I believe I have shown that there is a powerful force acting in that direction, and that it is producing its due effect, which sounds very much like the same thing.

On Recent Proposals Regarding Habitual Drunkards and other Offenders. By A. WOOD RENTON, Barrister-at-Law, and D. YELLOWLEES, M.D.

By MR. WOOD RENTON.

Viewed from the Legal Standpoint.

Within the last two years no less than three Parliamentary Reports, dealing with the problems presented by the familiar phenomena of inebriety and recidivism, have been published,* and a measure† designed, and, to a large extent, calculated to carry the main recommendations embodied in these documents into effect, has been read a second time in the House of Lords, under the pilotage of the then head of English legal administration. These facts show that public opinion has at length been thoroughly

* Cf. "Report of Departmental Committee on Habitual Offenders, Inebriates, etc., (Scotland)," 1895, c. 7,753. "Minutes of Evidence," 1895, c. 7,753-1. "Report of Inebriates (Departmental) Committee," 1893, c. 7,008. "Minutes of Evidence," 1893, c. 7,008-1. "Prisons (Departmental) Committee," 1893, c. 7,702.

† Lord Herschell's Inebriates Bill, 1895, P.P. 122.

aroused as to the necessity for fresh legislation on the subject of habitual drunkenness and crime, and render any preliminary historical sketch of the growth of the movement, which is apparently at last on the eve of attaining its objects, superfluous. If there is any member of the medical or legal profession who is still in ignorance of the process by which the problems in question have been brought to the stage of perfect ripeness for legislative solution, he may be referred with confidence to an admirable summary of the Parliamentary history of legislation affecting inebriates by Mr. Legge, the Secretary to the Inebriates Committee, 1891, which forms the 6th appendix to the minutes of evidence taken by that body, and is reproduced, with some additions and alterations, as Appendix M in the evidence taken by the Scottish Committee of 1894, and to the three Parliamentary Reports which have suggested the present review (see note, *sup.*).

I shall approach the subject matter of this article along two principal lines of inquiry.

- I. Proposals affecting habitual drunkards, to whom the provisions of the Inebriates Acts, 1879 and 1888, are applicable.
- II. Proposals affecting recidivists and habitual drunkards who come within the action of the criminal law.

I. Habitual Drunkards and the Inebriates Acts.

Borrowing a hint from Hogarth, let us consider the "progress" of the habitual drunkard's relationship to the legislation of 1879 and 1888, and the various difficulties and obstacles that arise in the course of it.

1. *The definition of habitual drunkards under Sec. 3 of the Act of 1879.* "Habitual drunkard" means a person who, not being amenable to any jurisdiction in lunacy, is notwithstanding, by reason of habitual intemperate drinking of intoxicant liquors, at times dangerous to himself or herself, or to others, or incapable of managing himself or herself, and (which, *semble* means *or*) his or her affairs. The first question arising under this definition is whether an applicant for admission to a retreat is an "habitual drunkard." The answer to that question, again, depends on the answers to several subsidiary ones. Is he "amenable to any jurisdiction in lunacy?" An habitual drunkard is amenable to the jurisdiction in lunacy, *i.e.*, the jurisdiction created or regu-

lated by the Lunacy Acts and Rules, if his indulgence has generated in him a condition of mental disease incapacitating him for the management of himself or his affairs. Where this condition exists, therefore, a man is not, and where it supervenes he ceases to be,* an habitual drunkard within the meaning of the Act of 1879. It will be observed, however, that the words used are not *the*, but *any* jurisdiction in lunacy. It is conceived, therefore, that the power of justices under Section 2 of the Criminal Lunatics Act, 1838, to deal with deranged persons purposing to commit crime, is a jurisdiction in lunacy with the meaning of this definition, and that where the circumstances contemplated by that Section exist the Inebriates Acts are inapplicable. Again what is "intoxicating liquor?" Although a case is recorded of excessive tea drinking having been treated under the Acts,† it is scarcely to be expected that, if the matter arose judicially, any other liquors than alcohol and possibly such commonly used intoxicants as ether or methylated spirits would be held to come within this part of the definition. There is great room for amendment in the statutory definition of "habitual drunkard." If Dr. Batty Tuke's suggestion before the Scottish Committee of 1894 (Ans. 12,681), that an habitual drunkard should be defined as meaning and including every person certified to be so (by the judicial authority) or voluntarily submitting himself for treatment, is unsatisfactory—and personally I think there is much to be said for it—narcotic and sedative drugs, and any intoxicating liquor whatever, should be specifically added to the existing definition. In Lord Herschell's Bill (sec. 19), the words "habitual intemperate drinking of intoxicating liquor or habitual use of opium or any other drug" were used. The provision in the St. Saviour's license—referred to in Dr. Kerr's evidence before the Committee of 1891 (Ans. 1,347)—inebriety "induced either by the use of alcoholic liquors or opium, morphine, or other

* Cf. Rule 5 of the "Model Rules of 1888." If any patient admitted into or detained in the retreat shall be found to be, or shall while in the retreat become insane, the licensee shall immediately give notice thereof by registered letter to the inspector, to the person by whom the last payment for such patient was made, and to one at least of the persons who signed the statutory declaration under section 10 of the Habitual Drunkards Act, 1879, and also to the relieving officer of the union or parish in which the retreat is situated, to the intent that the patient so being or becoming insane may forthwith be placed under proper care and control as a lunatic.

† Committee of 1891. Evid. 1893. C. 7008-1. Ans. 894.

narcotic or intoxicating or stupefying substance"—is more comprehensive. It would also seem to be worthy of consideration whether the word *inebriates* should not be substituted for *habitual drunkard* in all cases. This would involve the preparation of a codifying instead of a merely amending Bill. But for some reason or other the persons for whose benefit this legislation is intended seem to object to be styled habitual drunkards; the legislature has already met this susceptibility by changing the name of the statute of 1879 in the Inebriates Act, 1888, and the alteration might just as well be effected throughout.

2. *The formalities attending the admission of patients to retreats.* One of the formalities prescribed by the Act of 1879—the necessity created by sections 3 and 10 of that statute for the attestation of two justices *having jurisdiction under the Summary Jurisdiction Act in the place where the matter requiring their cognizance arose*—was got rid of by sec. 3 of the Act of 1888. Any two justices may now attest the application. But there is still ample work for the scythe of the "ignorant law reformer" in the luxuriant crop of obstacles to the admission of patients that still remain. The reports of the Scottish and English Inebriates Committees concur in recommending the creation of further facilities for the admission of patients to retreats, and Lord Herschell's Bill empowers the Secretary of State to make regulations for this purpose (sec. 13, sub-sec. 1). The fact must not be lost sight of that although provision is made for the *compulsory* committal of inebriates, a subject to which I shall return presently, voluntary committal will still remain a part, and a most important one, of the inebriates legislation. In the present state of the public temper on the question it is unlikely that compulsory committal will be legalised except under more than adequate safeguards against abuse. But there is no reason why the existing obstacles to voluntary admission, viz., the necessity for attestation by *two* magistrates and the requirement of two witnesses, should not be done away with, whatever concessions to public opinion in regard to compulsory committal may have to be made. Any Bill for the amendment or codification of the Inebriates Acts should, therefore, contain clauses simplifying in the way above indicated the admission of voluntary patients into retreats. Lord Herschell's Bill did not do this, and the omission is, I venture to think, a serious one. The deadly certainty with

which the resolution of very many applicants for admission into retreats evaporates while the stately minuet of preliminary steps prescribed by the Act of 1879 is being performed is well known to all who have any practical knowledge of the working of the statute.

3. *The committal of inebriates to retreats.* The necessity for powers of compulsory committal is still denied in some quarters. But it has really been established beyond the reach of argument long ago. The reports of, and evidence taken by, the Committees of 1872, 1891, and 1894, and the valuable returns by Dr. Hoffman, the Inspector of Retreats, show conclusively that if the area of the plague of inebriety is to be cut down to any very great extent the victims of its ravages must be sequestered whether they will or not. At present the vast majority of the class for whose benefit the Inebriates Acts exist, do not and cannot be compelled to take advantage of them. Moreover, the entirety of the "voluntary" principle, which adverse critics of the Inebriate reform movement speak of as if it were a palladium to tamper with which would involve the downfall of the whole social fabric, has already been sacrificed. Not only are patients who submit themselves to treatment now compelled to remain in confinement for the period during which they have undertaken to be detained and recaptured if they escape, but in many—possibly one might say without substantial exaggeration in most—cases the application for admission is not a voluntary one. It is the result of strong pressure brought to bear on the patient by his friends, and backed by threats to deprive him of supplies unless he yields to it. The case for compulsion is overwhelming in its completeness and strength. The question as to the machinery by which it is to be carried into effect is, however, not free from difficulty. The *Victorian Inebriates Act*, 1890, referred to by Dr. Kerr in his evidence before the Committee of 1891 (see report, p. 6), vests the jurisdiction in a master in lunacy, a County Court judge, or a police magistrate. The Committee of 1891 dispensed with the master in lunacy for this purpose—in all probability wisely, since the objection of inebriates to be styled "habitual drunkards" would be trivial indeed compared with their antipathy to the apparent stigma involved in the adjudication of their cases by a master in lunacy. The Scottish Committee of 1894 propose for Scotland the sheriff (or sheriff substitute), presumably in open court, as the person to be committed may elect (Report,

p. 4). In Lord Herschell's Bill, the High Court of Justice in England and Justiciary in Scotland and a County Court judge, sheriff, or sheriff substitute are alone invested with powers of compulsory committal (see secs. 1 and 17 (a) (b)). There would seem to be no reason why a stipendiary magistrate or specially appointed justice of the peace, as in the case of applications under the Lunacy Acts, should not be qualified.

4. *The time of detention.* The present maximum of detention in a retreat, viz., 12 months, is admittedly too short, and the Committees of 1891 and 1894 agree in recommending a two years' maximum, a point on which they are supported by Lord Herschell's Bill (see sec. 1, sub-sec. 1, and sec. 10).

5. *Conformity with rules.* Although the provisions in sec. 25 of the Habitual Drunkards Act, 1879—that if an habitual drunkard while detained in a retreat wilfully neglects or refuses to conform to the rules thereof, he shall be liable, on summary conviction, to a penalty not exceeding £5, or, at the discretion of the court, seven days' imprisonment—appear to be sufficiently distinct and stringent in theory, in practice licensees complain that they have no adequate means of compelling patients to comply with the prescribed rules and especially to work. One is tempted to think that the infrequency with which, according to the Inspectors' reports, the assistance of the court has been invoked under this section, may have something to do with the difficulty in question. But Lord Herschell's Bill contains a clause (sec. 2, sub-sec. 4) making wilful neglect or refusal to do work prescribed by regulations under the Act an offence—punishable by a fine not exceeding £5 or seven days' imprisonment. This would obviate any further misapprehension on the point. It might be as well to extend the provisions to *exercise* as well as *work*. There is also room for specific legislation to meet the case, so constantly cropping up in the evidence taken before both Committees, of an inebriate who endeavours to bring about his own discharge. It is absurd to allow the Acts to be frustrated by so obvious a device.

6. *Recapture on escape.* As the law at present stands, an inebriate escaping from a retreat, or from the person under whose charge he has been placed under license, cannot be speedily retaken. First, the licensee has to swear an information, then a magistrate or justice having jurisdiction (a)

in the case of escape from a retreat, in the place or district either where the retreat from which he escaped is or where the patient is found, and (b) in the case of an escape from a person in charge under a license—in the place where the patient is found, has to issue a warrant (sec. 26, Act of 1879). Lastly, this warrant has to be executed. In many cases the delay that intervenes between escape and the issue of the warrant makes recapture impossible. In regard to this subject Lord Herschell's Bill is defective. It does indeed supply the *casus omissus* in the 26th sec. of the Act of 1879 by enabling any justice having jurisdiction in the place where a person having charge of a patient resides, to issue a warrant if the patient escape (sec. 11, sub-sec. 11). But it not only fails to do anything towards simplifying the recapture of escaped inebriates, but weakens the existing law by providing that the time between the escape of a patient and his return to a retreat or to charge shall be deemed to be part of his term of detention (sec. 11, sub-sec. 2). The Committee of 1891 recommend the simplification of the procedure for recapture, but do not condescend in detail on the manner in which it is to be accomplished. The sworn information ought to be dispensed with, and if a complaint by a licensee or person in charge to a policeman is not sufficient, at least any justice should be enabled to issue a warrant. In concluding this portion of the present review it is only necessary to refer in terms of cordial approval to the following suggestions made by one or other of the two Committees: (a) that the Secretary for Scotland should exercise in the case of Scottish retreats all the powers of the Home Secretary in England and Wales (Report, 1895, p. 55. Cf. Lord Herschell's Bill, 17 (e)); (b) that the Procurator Fiscal should have power to apply for the compulsory committal of habitual drunkards who are a source of danger and annoyance to the public (*ib.* p. 56); (c) that the fees for licenses should be greatly reduced; and that the grounds of discharge under sec. 18 should be *personal* to the patient. In this connection it may be interesting to refer to a case brought before the Committee of 1891 (see Report, p. 7), where a husband (a publican) succeeded by an application under section 18 of the Inebriates Act, 1879, in getting his wife removed for the purpose of assisting him in his business before the period of her detention had expired, with the result that she relapsed into drunkenness; (d) that the establishment of retreats should be encouraged for those who

cannot provide the whole of the funds necessary for their maintenance, the residue being supplied by voluntary contributions (Report of 1895, p. 55).

II. *Recidivists and Habitual Drunkards who come within the Criminal Law.*

These two classes may conveniently be considered together, as they require similar treatment. The English and Scottish Committees and the Departmental Prisons Committee, 1894, concur in recording this opinion. Nor is there any disagreement between them as to what the general nature of that treatment must be. The case is put in a nutshell by the Prisons Committee, 1894 (Report, p. 31):—

“It is clear from the evidence that while the habitual prisoner is orderly and easily managed, the prison *régime* has little or no deterrent effect upon him unless he is subjected to long periods of imprisonment and penal servitude, which, however, frequently make him desperate and determined when again at large not to be taken alive. But there is evidently a large class of habitual criminals not of the desperate order, who live by robbery and thieving and petty larceny, who run the risk of comparatively short sentences with comparative indifference. They make money rapidly by crime, they enjoy life after their fashion, and then on detection and conviction they serve their time quietly with the full determination to revert to crime when they come out. We are inclined to believe that the bulk of the habitual criminals at large are composed of men of this class. . . . Upon the evidence given to us we are strongly of the opinion that further corrective measures are desirable for these persons. When under sentence they complicate prison management, when at large they are responsible for the commission of the greater part of undetected crime; they are a nuisance to the community.

“To punish them for the particular offence in which they are detected is almost useless; witnesses were almost unanimous in approving of some kind of cumulative sentence; the real offence is the wilful persistence in the deliberately acquired habit of crime. We venture to offer the opinion formed during this inquiry that a new form of sentence should be placed at the disposal of the judges by which these offenders might be segregated for long periods of detention during which they would not be treated with the severity of first-class hard labour or penal servitude, but would be forced

to work under less onerous conditions. As loss of liberty would to them prove eventually the chief deterrent, so by their being removed from the opportunity of doing wrong the community would gain.

“Under this head should be included most prisoners sentenced primarily for drunkenness. They are not criminals in the ordinary sense and should stand by themselves in a special category. Our inquiry entirely confirms the recommendation of the Departmental Committee on Inebriates, that magistrates should have power to commit for lengthened periods habitual drunkards coming before them. The physical craving for drink is a disease which requires medical treatment not provided by the present prison system.”

It is scarcely necessary in writing for the *Journal of Mental Science* to observe that criminology justifies to the letter the views expressed in the paragraphs above quoted (Cf. *L'uomo delinquente* and *Elmira*, by Winter).

The details of the proposed treatment are not, however, so easily settled. First comes the difficulty of defining an “habitual criminal.” The returns laid before the Prisons Committee show that when an offender has been convicted a fourth time or more, “he or she is pretty sure to have taken to crime as a profession, and sooner or later to return to prison for the fifth time or more.” The “Inebriate Reformatories” provisions of Lord Herschell’s Bill (sec. 4), whose drastic character brought it into such bad odour with certain classes, were applicable if the Court was satisfied by evidence on oath that a person—(a) convicted of being drunk in a public place or on licensed premises and having more than once during the preceding twelve months been convicted of the like offence or of any other offence involving drunkenness as part thereof, or (b) convicted of an offence punishable with imprisonment or with penal servitude—was an habitual drunkard. The Prisons Committee make the following observations on this subject:—“We have not attempted a definition of ‘habitual criminal.’ This is a question which necessarily must be taken in conjunction with our suggestion that a new form of sentence should be set up. To lay it down that a prisoner should be regarded as an habitual criminal does not meet the case. Coiners, receivers, and other criminals by profession, frequently escape detection for long periods, and it would be necessary to bring this class into the category of habitual criminals.

For this purpose it probably would be necessary to give a certain amount of discretion to the Court."

The Scottish Committee's method of impliedly defining "habitual criminal" meets the point of this criticism without giving too vague and indeterminate results. The Sheriff is to be empowered to find that a person who, having been imprisoned three times within twelve months, is again brought up before a magistrate, is an "habitual offender," with consequences to which allusion will presently be made. If any definition of "habitual criminal" is attempted, it ought to be sufficiently general and elastic to leave the Courts that have to apply it considerable freedom of interpretation.

The next points to be settled are where and for how long recidivists and habitual inebriates are to be segregated. Special wards attached to ordinary prisons have been suggested. But, even as regards the recidivist, this proposal is not free from objections, and in the case of the habitual drunkard it is inadmissible. It would destroy prison discipline. On this point the evidence of Captain Stopford ("Evidence," 1893, c. 7,008-1, Ans. 1,918-30), one of the Prison Commissioners, before the English Committee, is clear, and, it is thought, conclusive; moreover, it would be of comparatively little benefit to inebriates. The knowledge that they were under a milder *régime* in ordinary prisons would act in contrary ways on different classes of patients. In some cases, even this remote association with ordinary criminals would keep alive in their minds the criminal instincts which the whole object of the separate treatment is to eliminate. In others it would create an impression that they were a privileged class and were consequently entitled to be refractory, and thus the work of reformation would be retarded. Either of these results would be mischievous. Lord Herschell's Bill provided for the appropriation of any building vested in or under the control of the Secretary of State, *including any prison*, as an inebriate reformatory. Subject to the foregoing criticisms as to prisons, this is the right solution of the problem. The Scottish Committee recommend the institution of labour settlements in a series of paragraphs in their valuable Report (pp. xvii *et seq.*). The suggested scheme is as follows:—If at any time a person whose name is on the register of habitual offenders is again charged with an offence, he will be tried by the Sheriff, who is to have power not only to sentence him, but to order his detention on discharge from prison in a

labour settlement for a period of not less than 12 nor more than 30 months (the five years' maximum in Lord Herschell's Bill is too high for the present state of public opinion). In these labour settlements the inmates are to be put to such work as they are capable of, as far as possible in the open air, and selected with a view to give the inmates the best possible chance of obtaining remunerative employment on their discharge. The settlements are to be placed under the control of the Secretary for Scotland, who is to have power to frame rules for inmates and officers (any infraction of which will constitute a statutory offence), to liberate inmates conditionally or unconditionally, or to send them out on license in the same manner as is at present done with the inmates of adult reformatories. Assuming that the financial basis of the proposal is sound,* I venture to think that it would be well worthy of a trial. *Mutatis mutandis* it could be readily adapted to the case of inebriates. It is just possible that owing to the exigencies of what the Legislature may deem more pressing business, the law as to inebriates and recidivists may not be amended with quite the expedition which the case demands. If unhappily any such delay seems imminent, it might be well to attempt to secure at once such an alteration of the Inebriates Acts as may enable cases like that of Jane Cakebread, who has recently undergone her 278th sentence for drunkenness in Holloway Gaol, to be dealt with under them. The existing licensed retreats are practically confined to paying patients, and therefore even if this wretched woman can be induced to go to the cottage home in which Lady Henry Somerset and Mr. Thomas, one of the missionaries of the Church in England who are attached to the Police Courts, have made arrangements for her reception, she cannot be compelled to remain there. There ought to be no objection in any quarter to the provisions in the Inebriates Acts as to *compulsory detention* being at once extended to cover cases of this description. They are by no means uncommon. Mr. Holmes states that in a single week four women came before a single stipendiary who between them had been convicted more than 400 times

* The Committee look for the necessary money to—(1.) The labour of the settlers, put at about £14,000 a year, assisted by an annuity of £10,000 from the Imperial Exchequer; (2.) A Labour Settlement Fund arising out of fines now paid by prisoners after their admission to prison, and those lost for want of prosecution; and (3.) If necessary a levy for the deficit on fines and pledges received by local authorities in Scotland.

for drunkenness and disorderly conduct. If we may not yet commit miserable wretches of this class against their will, we surely cannot object to allow them to commit themselves to any proper custody, and to see them held strictly to their bargain.

By DR. YELLOWLEES.

Habitual drunkenness may be a mere vice which enslaves and degrades its victim, and produces characteristic moral and physical degeneration. The special temptation to its victims seems to be in the exhilaration experienced during the process of intoxication, for one of them declared that there was no pleasure in *being drunk*, but that *getting drunk* was glorious. For this indulgence all considerations of duty, affection, or personal advantage are deliberately ignored or defied, with results disastrous to the individual, wretched to all dependent on him or connected with him, and often injurious to the community.

Some drunkards with originally stable brains and good digestions develop no brain trouble beyond perhaps an occasional attack of delirium tremens. Others develop more marked forms of brain disorder, the brief *mania a potu*, the sub-acute and more or less prolonged insanity of intemperance, with its morbid suspicions, hallucinations, and delusions, general paralysis, climacteric melancholia, or, ultimately, chronic alcoholism. Besides these manifest forms of brain disorder, other mental changes, less obvious but scarcely less baneful, are invariably found. The habit of intemperance, like all other habits, grows more powerful by indulgence, and the invariable result of habitual intemperance is such weakening of will power that temptation is less and less resisted, and such blunting of the moral sense that the drunkard ceases to feel the sin and shame of his own degradation or the misery he inflicts on others.

In another class of cases, and these are usually cases with a neurotic inheritance, the desire for drink becomes a passion so overmastering and intense as to constitute in itself a brain disorder, and this passion is associated with such a degree of moral degradation as confirms this view of its origin. Truth and honour, duty and affection, are unknown or unheeded in dipsomania. The disease may be acute, and reckless indulgence is fatal in a few months; it may be paroxysmal,

when its victim is alternately a sober, upright man and a degraded and demoralized drunkard, or it may be a chronic state of moral degradation and perpetual attempts to get drink.

Dipsomania, a term which is properly applicable only to this second category of cases, is originated, in the vast majority of instances, by intemperate habits, but in very rare cases it may follow brain injury or mental shock in persons previously of sober habits, or it may be an inheritance from intemperate ancestors. If the habitual inebriate, to whichever class he belongs, were the only sufferer by his indulgence, it would be sad enough; unfortunately he not only wrecks his own life, but is a curse to his home and a pest to society. In ruining himself he brings ruin and misery on those most nearly connected with him, and often endangers their lives by reckless violence; while as regards the general community 90 per cent. of the convictions for assault and disorderly conduct in the Police Courts of Scotland are directly due to drinking, and are committed either by the habitual inebriate or by those qualifying for that title.

How, then, is the habitual inebriate to be dealt with so as to save him from himself and to minimise the evil wrought by him?

The essential treatment is obvious. Entire withdrawal of alcohol, and physical and moral regeneration.

Any attempt at reformation without removing the cause would be obviously futile, and mere deprivation of stimulants may only increase the desire to get them, unless an improved tone of physical and moral health can be established.

The treatment is as easy to enunciate as it is impossible with our present powers to carry out. Even when the habitual inebriate honestly desires to be delivered from his love of alcohol, and will accept guidance, the treatment is most difficult. The good resolutions and solemn promises are all forgotten on the first opportunity of indulgence, and while it may be possible to safeguard a wealthy man by placing him in an isolated home and surrounding him with uncorruptible servants and companions, what chance has the less affluent inebriate, especially if he dwells in a city cursed by drink-shops at the corner of every second street?

Various are the fates which may befall the habitual inebriate with or without his own consent, in the anxious and often futile efforts of his friends to save him.

1. With his own consent, but under the cogent advice of friends—and their advice is cogent only when they fortunately have the power of stopping the supplies—he may go for a limited period into a licensed home for inebriates, but his consent must be given in writing before two magistrates, who must see that he fully understands what he is doing when he signs away his liberty.

The majority of inebriates cannot afford to go into such homes, and the worst cases refuse to go at all. Many who do go come out far too soon, get very little good, and only resume drinking with fresh energy.

2. With his own consent, and under like moral compulsion, he may become a voluntary patient in a lunatic asylum if a superintendent can be found who will receive him. Sometimes, though rarely, this plan answers well, if the case be not confirmed. The patient is contrite, is solemnised by the effects of indulgence as seen around him, distrusts his own strength, and deems the asylum a place of deliverance and safety. For such a man there is hope, but a different kind of refuge should have been open to him.

Usually a confirmed inebriate is an injurious and unwelcome inmate of an asylum for the insane, and the element of direct authority and coercion which is essential to his right treatment, is contrary to the spirit of an asylum. He frets at the rules, and tries to evade them; he despises his fellow-patients as lunatics, and grumbles at association with them; he delights to report and to exaggerate every unpleasantness to his friends, and poses as the victim of their ignorance and unfeelingness.

On the other hand, respectable lunatics soon detect the hypocrisy and falsehood so characteristic of the class, and they object, and properly object, to be associated with demoralised drunkards.

3. With his own consent and under like compulsion, the habitual inebriate may be sent to reside with a country doctor, or minister, or some selected companion, from whose moral influence and restraint something is hoped for; or he may be boarded with strangers in a house which receives several such inmates, or at a farm, or on some remote island where alcohol can with difficulty be obtained; or he may be sent on a long sea voyage in a temperance vessel, or shipped off to Australia or to anywhere else, to sink or swim as he may, if only he keeps away from the friends whom he disgraces.

Successful results are sometimes attained by suitable companionship and the constant pressure of strong moral influence, but the boarding-out plan usually fails, and indeed is scarcely expected to succeed. It is often a "can-do-no-better" method, whose chief benefit is that it lessens the disgrace and immediate annoyance to the friends, and secures a comparative degree of abstinence, from the want of money and the difficulty of obtaining drink. Only in the cases where the habit is not confirmed, and where strong moral influence is exerted by the guardian, is self-respect awakened and moral regeneration attained. Without such regeneration the gain is small indeed, and relapse into the old habits is certain sooner or later to follow. The greater the confidence with which the patient announces that he has conquered his weakness and will never touch liquor again, the sooner and the more certainly will he break down. Deprivation without regeneration does no permanent good.

4. Lastly, and by his own act, the habitual inebriate may find himself in prison, not once or twice, but scores or hundreds of times, for one or other of the many petty offences due to drink or the craving for it. The great majority of the habitual petty offenders who are the pests of our police courts are habitual inebriates. The short imprisonments which they are continually receiving rid the community of them for a time, and improve their own physical health by placing them in hygienic conditions, but the periods are so short that they whet the craving for drink rather than allay it, and the old habits are eagerly resumed whenever they leave the gaol. A more futile or a more extravagant mode of dealing with habitual inebriates could hardly be devised.

If so little can be done for the habitual inebriate with his own consent, whether given or extorted, what can be done for him without his consent? The melancholy reply—a reply disgraceful to our boasted legislation—is, nothing. If he continues his vicious indulgence until he becomes a *lunatic*, we seclude and treat him under the lunacy law; if he continues it until he becomes a *criminal*, we seclude and punish him under the criminal law. Failing either of these consummations—often devoutly desired by his friends—he continues his career of disgrace and ruin, a curse to his friends and a pest to society, until he dies a drunkard's death—another martyr to that National craze, "the liberty of the subject." Our laws punish the man who attempts

suicide, though the act might injure none but himself, yet they deliberately allow the habitual inebriate to commit slow suicide of the most degrading kind, and to be a curse and a danger to others in the process. No one who has intimately known the wretchedness, ruin, and danger caused by an habitual drunkard ever doubts the necessity for compulsory confinement. It is little wonder that death by suicide or accident has often been longed for by the helpless friends as their only hope of deliverance, or that unprincipled relatives have, in despair, deliberately given the habitual inebriate unlimited credit at a drink shop in order that he might kill himself as speedily as possible.

The recent appointment of Parliamentary Committees to consider this question indicates a sense of public uneasiness on this subject. The report of the Departmental Committee appointed to investigate this and allied subjects in Scotland, whose chairman was Sir Charles Cameron, Bart., M.D., has recently issued its report, and the evidence on which that report is founded. These documents are of the greatest value, and should certainly produce important practical results. The testimony given before the Committee was singularly unanimous and emphatic. It was reiterated by every witness, lay and medical alike, that the first step towards cure was entire and prolonged abstinence; that such abstinence was possible only when indulgence was made impossible; that voluntary seclusion was utterly declined by the cases which needed it most; that in the interest of the patient, his friends, and the public it is urgently necessary that, when sufficient cause is shown, there should be a power of compulsory seclusion, with a view to treatment; that the treatment should include physical occupation and moral influence; that the result of treatment should be tested by trial; and that failure should imply longer seclusion and further treatment.

This testimony is so manifestly consistent with truth and common sense that it seems needless to amplify it. Voluntary seclusion as authorised by the Habitual Inebriates Act, has utterly failed to meet the necessities of the case. The worst inebriates laugh at the idea of signing away their liberty, and the great majority of those who consent to their seclusion would have equally consented to it without any act at all. So utterly futile has the present Act been deemed that there is not a single licensed retreat such as it authorises in

all Scotland. The futility of voluntary seclusion was foreseen by the framers of the existing Act, who did their utmost to obtain compulsory powers, and were supported in their efforts by the strongest medical testimony, but that old bugbear the liberty of the subject so oppressed our legislators that the promoters of the Bill had to choose between its total rejection and the withdrawal of the compulsory clauses.

Happily that bugbear is rapidly losing its obstructive power, and the portentous consequences which interference therewith was alleged to produce, have proved to be blessings. The liberty of the subject is now interfered with in many ways greatly to the benefit of the subject and of the community. He is compelled to vaccinate his children, to report infectious disease, to isolate the patient, to disinfect the house. He is compelled to educate his children, he is compelled to pay rates for police protection and public sanitation, he is compelled to regulate his life and work so that he shall not annoy others. He is compelled to seek legal authority and obey legal restrictions before he can engage in certain kinds of business. He is compelled to register births, deaths and marriages in his family, and he cannot even be buried without a legal certificate.

After all this interference, it is something more than absurd to allow an habitual inebriate to ruin himself and his family, imperil their lives and his own, and endanger the community around him, because, forsooth, you must not interfere with this empty old Shibboleth "the liberty of the subject."

Other lands put us to shame in this matter; Austria has quite recently adopted the compulsory powers without which our law is useless.

The recommendations of the Committee are clear and strong for compulsory powers. While wisely retaining the arrangements of the present Act as regards the licensing and inspecting of retreats and the power of entering them voluntarily—subject always to such modifications by the Secretary of State for Scotland as experience has shown to be desirable—they recommend that the Sheriff, either in chambers or in open court (as may be desired by the inebriate), shall have power to take evidence, and on sufficient cause being shown, shall have power to commit an habitual inebriate to a retreat for any period not exceeding two years. The Sheriff shall have power at the same time to appoint if necessary a Curator to look after his affairs and

to instruct the payment from his estate of whatever sums the Sheriff may deem equitable for the support of those dependent on him.

The application to the Sheriff may be made by relatives or friends, or by the Procurator Fiscal; this last is a most important provision, for many inebriates after liberation might revenge themselves on those who sought their seclusion.

The retreat to which habitual inebriates of the lower social grades would be committed would be one of the Labour Settlements—practically Industrial Reformatories—which the Committee desire to establish at various places throughout the country, in which residence, abstinence, and occupation would be alike compulsory, but where reformation, not mere confinement, would be the constant aim.

These Settlements are to receive vagrants, beggars, habitual petty offenders, and habitual inebriates. The mixture sounds very hopeless, but legislation cannot sift the social dregs too finely; what is salvable can only be got out by the patient personal efforts of those who have charge of them, and these efforts would be quite useless without such compulsory powers.

Public opinion in Scotland is fully ripe for the legislation proposed, and most earnestly desires it.

The Uses and Limitations of Mechanical Restraint as a means of Treatment of the Insane. By P. MAURY DEAS, M.B.
Lond., Wonford House, Exeter.

I do not wish to enter into any dissertation on the question of mechanical restraint, as such, or to conduct the discussion into an academic debate on the ethics of mechanical restraint. I want to take a more limited view. I want this discussion really to be, if possible, an interchange of views as to the best way of treating and managing certain difficult and exceptional cases which crop up every now and then. I propose to give you the benefit of my experience in dealing with some exceptionally difficult cases, in which I have found a modified use of mechanical restraint beneficial to the patient.

Now, in regard to this subject I make one or two preliminary remarks. I have had the advantage of having had experience both in a large county asylum for fifteen years, and also now for a considerable time in a hospital for the

insane for a different class of patients—patients of the so-called higher and educated classes; and I think that there is a considerable difference as regards the occurrence of these difficult and intractable cases. I am bound to say that, as Superintendent of the Cheshire County Asylum, the number of cases in which I felt at all inclined to use mechanical restraint was extremely small. In fact, there was but one, and that was exceptional, which rather tends to prove my statement, as it was the case of a private patient, of quite a different class to the rest. It was the only case to which I can look back and say that I would like to have used mechanical restraint, and your present secretary, Dr. Macdonald, whom I had then the pleasure of having with me as medical officer, will be able to bear me out that I was then as strong an opponent of mechanical restraint as could be found anywhere. Brought up in a school which looked upon mechanical restraint as an opprobrium, and a thing that should never be entertained, except under pressure of very extreme circumstances, I am bound to say that my experience here during the last eleven years has led me to modify that view, and my opinion now is that there is certainly a class of cases received here in which the use of mechanical restraint is beneficial.

Now I want in the first instance to point out some limitations as to the use of mechanical restraint. First of all, limitation as to cases. I think that it should never be used except for the protection of the patient; and not for cases of violence or destructiveness. These can be dealt with in other ways. I still adhere to the opinion that I have always held on that point.

Then, secondly, as to the limitation of means. My observations are concerned with the means for limiting the movements of the arms and hands. I have nothing to say on the question of general restraint, or modes by which the whole body is restrained, and express no opinion about them. I have had no experience of them, but it seems to me that they are attended by too much risk and by too many disadvantages to allow of their being used as a method of general treatment.

After these preliminary remarks I shall try to indicate shortly the kind of cases in which I think mechanical restraint may be used. There are, first of all, surgical cases. They do not offer opportunity for discussion. Then, with regard to suicidal patients. Ordinary cases can, of

course, be quite well treated by ordinary means; but my experience here has been that there are exceptional cases of this class—cases complicated with violence, and of a marked suicidal tendency, involving a great deal of struggling, which is injurious to the patient in many ways. These are the cases, in my opinion, in which mechanical restraint may be used with advantage. Then come those classed under the head of self-mutilation—perhaps a somewhat artificial distinction from the suicidal cases, but there is a distinction. I have had many cases of self-mutilation not distinctly suicidal, such as exhibit habits of flesh-picking, biting the fingers, or biting other parts of the body, pulling out hair, or eating rubbish. The other category of cases is that of sexual excitement, and self abuse in young women. The last is one in which I have the least hesitation in employing some means of mechanical restraint. It is essential, if possible, to stop the practice. I am satisfied that the keeping up of the practice of masturbation aggravates the excited condition of the patient, and that if one can break off the habit it is one's duty to do so, and there is, in my opinion, no method so effective as that of mechanical restraint. Of course that is not the only means. I am talking of cases which resist ordinary treatment, in which drugs and other treatment have failed. The illustrative cases I shall refer to presently are those in which ordinary means failed, and, as I believe, where no other means would have succeeded.

CASE I., that of a gentleman who made persistent attempts to gouge out his eyes. Gloves were worn for seven days, with the result that the patient improved, and there was no return of the symptoms.

CASE II., that of a lady, recurrent mania; the patient had had three previous attacks (not suicidal before) with delusions of fear and frenzy. She suddenly made a determined attempt to pull out her tongue, and was restrained by a sleeve dress for seventeen days. Result: rapid improvement; practically well in two months. Another attack two or three months later. Symptoms of acute mania. In two months very depressed and threatening suicide, and at the same time very violent and aggressive. She was placed in a side-arm dress for twenty nights. Result: rapid improvement and well in two months. Another attack nine months afterwards; not suicidal. Recovered in four months, and has kept well now for over four years.

CASE III., that of a lady. Climacteric ; delusions of fear and suspicion ; hallucinations of hearing. There was a temporary improvement for a month or two, then a relapse into a condition of confusional insanity, with a tendency to violence. Much improved again after four months. Went to our Convalescent Home at Dawlish for a change. While there had a sudden outbreak of suicidal mania ; tried to throw herself out of window and to cut her throat. Became very violent, refused food, and was exceedingly suicidal, with acute delusions of fear. For over two months she wore her arms confined by a sleeve dress ; at first day and night, and after a time by night only. She then improved rapidly, and in three months appeared convalescent. That is the history of that case, so far as suicidal tendency is concerned. After two or three months another symptom occurred ; she began to pick the skin off her face and arms, causing sores. For a month she wore padded chamois leather gloves at night, after which the flesh-picking tendency died away, and she improved steadily for six months, when she slowly relapsed, and the flesh-picking began again. For over a month the gloves were worn night and day, when the habit was again broken. Mental improvement was very slow, symptoms of insanity of doubt remaining for a long time. After a year improvement was more decided, but it was only at the end of another year that she was well enough to face the world again. She returned home in the spring of 1893, nearly five years after the commencement of her illness, and has remained perfectly well up to the present time.

CASE IV., that of a lady with strong hereditary predisposition, suffering from acute melancholia. She was very depressed, excited, and violent to herself and others. Tried to injure herself in various ways, knocking her head, pulling out her hair, refusing food. Very aggressive, and if held, struggling most violently. She had many delusions. Six months after admission, restraint was first used in the form of padded gloves, to protect her, to avoid struggling, and to check self-abuse, to which she was much addicted. These were employed, more or less, for two months. General condition improved for about three months. Thereafter, constant refusal of food, struggling and trying to injure herself. She was reduced to a state of general prostration, and but for being restrained I believe would have sunk from exhaustion. Sleeve dress and side-arm dress

used on 78 occasions out of 106 days, at first at night, and during the worst of the attack for six weeks day and night, with intervals, and after that with longer intervals. After this improved for several months; relapsed again, but into a stuporose state. Just a year after the last attack worse again, refusing food, with self-abuse. Wore gloves at night for sixteen nights. After this quiet for another year, health failing. Then for a month refusing food, struggling, trying to injure herself, self-abuse. Was restrained at night for twenty days by gloves or side-arm dress. After this a good deal better for six months; then refused food again, and had to be fed by tube almost continuously for three months; remained quiet. Died suddenly from cardiac failure and a succession of fainting attacks nearly four years after admission.

CASE V., that of a lady, suffering from acute delirious mania (strong hereditary predisposition) brought on by seeing her husband commit suicide. Very violent, refusing food. Ten days after admission tried to injure herself by putting her hands down her throat, &c. Was restrained at night by side-arm dress on 47 occasions. During this time improved very considerably, and did not again show suicidal symptoms, although the maniacal condition returned and remained chronic.

CASE VI., that of a lady with no hereditary predisposition, suffering from melancholia. Intensely depressed and suicidal, refusing food; hears voices; anæmic; amenorrhœa. Was bent on suicide, and tried it in so many ways, that for three days of the week after admission she was restrained by side-arm dress for thirteen to eighteen hours. In the next two months improved a good deal, and suicidal tendency less acute. Then worse again; jumped over rail on top of steps. Improved a little again, but seven months after admission became most acutely suicidal; tried to smother herself, and to put herself on the fire. Was restrained for 27 nights by side-arm dress. After this slowly improved, and had no return of the acute symptoms, but remained depressed. Twelve months after admission had improved considerably, and was soon after removed to another asylum.

CASE VII., a lady, religious melancholia; suicidal and homicidal. The patient attempted to smother the friend with whom she lived with a pillow; said she must kill her and then dash her own brains out. At the end of three

months she had considerably improved, when she was much upset by a letter, and in the night made a determined attempt to strangle herself with a garter and handkerchief, and was very violent after. The next day she attacked two nurses, and the following night tried to smother a nurse with a pillow; said she must kill someone. Then she wore gloves for 13 nights, improved gradually, and in three months was apparently well. Returned home in December, 1893, and has kept quite well since.

CASE VIII., of a lady (puerperal), acute melancholia, suicidal, with hereditary predisposition. She developed persistent flesh-picking, causing sores on face, hands and arms. Gloves or sleeve dress were worn for six months. After improvements and relapses, finally recovered in two years, and has remained quite well.

CASE IX., that of a young lady, with hereditary predisposition; mania; anæmia, and amenorrhœa. Had pulled out much hair; perverted appetite; ate anything, rags, sticks, bits of plants; tore up her clothes to eat. Wore gloves for eleven days with excellent moral effect. She begged to have them off; began to improve rapidly; in a month was convalescent, and in two more went home.

CASE X. Chronic mania, with hereditary predisposition, admitted in 1886. From time to time there was a tendency to scratch and pick her hands, and in 1888 and 1890 she was troubled with an eczematous rash on her face. In January, 1891, the eczema, rubbing, and picking continuing, padded gloves were tried. After three nights her face was nearly well. Restraint stopped for two nights; patient as bad as ever. After nine more nights' restraint, face almost well; restraint stopped three nights; result as before. Gloves continued night and part of day for seven weeks. Had begun to rub her face with gloves; sleeve dress used. After a month her face was well, and restraint was stopped. Next day there was a large sore on one side of the nose. In six days well, and restraint stopped for nearly a week, when picking and rubbing face again began. Restraint resumed for three weeks and face again well. No recurrence of the habit for five months, when, without any eczema, she again began picking her face. For seven nights gloves were worn, and she was better. After an interval of eight days it began again. For two weeks gloves were worn at night, and the habit was completely broken. That was four years ago, and it has not returned since.

CASE XI., a lady, admitted here in December last; hereditary predisposition, acute melancholia, addicted to self-abuse for months, worse lately. She was most intensely suicidal, and before admission had swallowed a bottle of liniment; tried to swallow some broken crockery; cut her wrists with broken crockery, and jumped over the banisters. The ordinary course was followed for six months, and she was very much worse, and after a time developed symptoms of acute nymphomania. Still suicidal, with most desperate struggling; in fact, it is the most exceptional and intractable case in my experience. From the 30th of May she has worn the sleeve dress confining the arms on 73 out of 130 days, about half of the time during the night and part of the day, and the rest of the time mostly at night. Since the end of July she has been under restraint only seventeen times, and for short periods during paroxysms of struggling and sexual excitement. That has been the case during the last six months, and it is very difficult to see in what other way she could have been managed. Two nurses, and sometimes three, could not restrain her, but, on her arms being confined, restraint in her paroxysms was comparatively easy. Every known drug, I think, has been used, and has been pushed freely. She is now quite as bad as on admission, and only yesterday attempted to commit suicide in one of her paroxysms.

Now, with regard to one or two points in conclusion. It seems to me that there are only three forms of alternative treatment. One is by manual restraint, the other is by drugs, and the third mode, which cannot be called treatment, is to allow the case to run its own course. I think that anyone who has seen exceptional cases, such as I have been trying to describe, must have a strong feeling that *something must be done to protect the patient*. Manual restraint, going on week after week, is not only impracticable, but very bad for the patient, leading to struggling and excitement just in the cases in which you want to conserve all the force and strength. In some, one is bound to use sedative drugs, but I would much rather do without them; and, given the choice between these strong medicaments and modified mechanical restraint, such as I have mentioned, I prefer the mechanical restraint. It does less harm in the long run, and if there is a possibility of recovery in the case

I think that the use of such drugs is more likely to retard or even prevent recovery.

Before sitting down I should just like to mention what may be considered to be the *disadvantages* of mechanical restraint. The first is that which I may, without being offensive to anyone, call to a certain extent sentimental. We all know that in the old days mechanical restraint was greatly abused, and that the great wave of improvement in the treatment of the insane was begun with the abolition of mechanical restraint. That influences our minds very much, and rightly. There is a feeling that it is demoralising to use modes of treatment which have been associated with such terrible evils in the past. But my opinion is that you have not said the last word when you have said that. I still think that, as physicians entrusted with the care of the insane, for whom we are bound to do the best we can, we must free our minds from the influences of tradition in regard to this matter; and that if we find a certain mode of treatment is useful in certain cases, we ought not to be debarred from using it by the fact that it has been abused in the past, or that it is officially discouraged in the present. Another disadvantage is that there is a temptation to keep it up too long. Certainly that is true. A similar argument applies to drugs or any means of restraining treatment. I do not think there is any greater possibility nowadays of using mechanical restraint in excess than there is of using drugs to excess; I hardly think so much. The third disadvantage is in the possibility of producing a bad moral or physical effect on the patient. My experience is that such fears may be disregarded. I cannot recall a single case in which there has been any bad effect, either bodily or mental. I have never heard patients complain afterwards of being restrained, while some are thankful for the restraint. I have heard them beg to have the gloves taken off, and to be freed from restraint, and so on, and that is a very powerful lever, especially where you can work on the patient's self-control.

I will now tabulate shortly what I consider to be the *advantages* arising from the use of mechanical restraint in these cases. The first is that there is greater security for the patient. You feel that you are doing your best and your mind is more at rest; you are able to check injurious habits, which it is extremely difficult, if not impossible to do—that

is my experience—in any other way. And then it is first of all constant; it does not relax in vigilance; it does not lose its temper; and these, I think, are very important matters. I think we are all inclined to expect too much from attendants and nurses. They are but human, and it is impossible to conceive anything more trying than the duty of preventing these patients from injuring themselves, of restraining them in struggles, and at the same time keeping a good temper and doing the duties imposed with anything like coolness. We are justified, I think, in cases of this sort in thus assisting the nurses and attendants in a way that does not go against the conscience, and in a way that does not do harm to the patient. Then a very great advantage is that it certainly husbands the strength of the patient, by preventing exhausting struggles and limiting the use of sedatives. That, to my mind, is the greatest advantage of all. Another is, I think, in some exceptional cases, that it tends to more real freedom for the patient in the way of exercise, the patient who is restrained in a modified way, such as I have described, being able to get out and move about.

Now I have come to the end of what I had to say on this subject and it only remains to invite suggestions and comparisons. I should like to know if any of you meet with exceptional cases of this sort, and the means that you adopt in treating them. My opinion is that the circular lately issued to us with regard to the use of mechanical restraint is one of the very feeblest productions that ever came from any responsible body of Commissioners. It is neither one thing nor the other: it tries to run with the hare and hunt with the hounds. If the Commissioners think what they profess to think, why do they not propose an enactment that mechanical restraint shall never be used? They know perfectly well, as well as I do, that if they were to succeed in having such a thing enacted, it would be absolutely impossible to carry it out. If we concur in such recommendations, we go far to invite suggestions as to the doses of medicine to be employed. We may even be within measurable distance of not being allowed to give some drugs at all.

My object in opening this discussion is that there should be a little more common-sense utilised in dealing with this subject, and that we should, at any rate, try to keep an open mind on the question.

Discussion on Dr. Deas' Paper.

Dr. WEATHERLY cordially agreed with what Dr. Deas had said with regard to suicidal and self-mutilating patients, but he was surprised to hear that restraint was only useful in cases of self-abuse in women. His experience had been absolutely the reverse. He had had a very lengthy experience of cases of masturbation in women. One case had been under his care for fifteen years, and another for a considerable time, and he candidly admitted that mechanical restraint for preventing masturbation in women was most unsatisfactory. Rubbing the thighs together was one, he thought, of the commonest forms, and how they were to stop that by a long sleeve jacket he failed to see. Dr. Langdon Down had a large number of these cases under his care, and he understood that the only means he (Dr. Langdon Down) believed could stop the practice in women was absolute constant supervision, and when the masturbating fit came on to immediately apply cold ice pads or cold water to the parts. He (Dr. Weatherly) had tried that in one case with a good deal of benefit, but the case left the hospital at the instance of her friends. With regard to masturbation by men, he thought here they certainly had a class of cases in which nothing, unless it was allied to mechanical restraint, would do any good. He had one case, especially, that he should like to bring before their notice. He had been in a London Asylum for acute mania, and came to him an absolute wreck. He could not say one coherent sentence; messed about his food; looked like an idiot; masturbated incessantly; defecated in his clothes; ate his motion, and in fact a more filthy patient he did not think he ever recollected seeing. He (Dr. Weatherly) tried all ordinary methods to stop his habit of masturbation without success, and then wrote to the Commissioners that the only hope was continuous mechanical restraint in a long sleeve jacket. They replied that he must take the responsibility; if it was a right and proper thing he ought to do it. That was before the mechanical restraint book came in, although it was in use before the man was well. For six months he was so restrained, and gradual improvement became permanent. He did not think that man's recovery could possibly have taken place without mechanical restraint. There was a class of cases which Dr. Deas had not touched upon, and which they had all no doubt had to deal with. He referred to those whom they could not keep in bed. They would be up all night, hammering at the doors and banging at the walls, until a condition of exhaustion supervened. He had one case in which he had had to bring the patient back from impending death with injections of sulphuric ether. He had in the case of a lady—the case of chronic masturbation which he had already mentioned—used the simple expedient of a sheet round the patient, properly fastened when in bed, and there had since then been no difficulty; she had remained in bed. She was getting thin, her heart was beginning to fail, and what he was to do he did not know, if such a simple measure as placing a sheet round her might not be used. If she was in a room with a nurse she was fighting all the night. Without the sheet he did not know how she was possibly to get that amount of rest absolutely required to keep her alive.

Dr. WADE said he had seen two cases in which mechanical restraint cured outbreaks of violence when nothing else would have done so. In both it might truly be said that the precaution was certainly taken for the benefit of the patient. He had a patient who always attacked anyone who came into the room, and as a result he was being knocked about by the other patients. He was in very bad health, and could not possibly be reduced further by drugs. He decided to restrain him and used a belt with the arms fastened to the sides. He released him on several occasions, but prematurely. After several months of this treatment, however, it proved successful. That was eight years ago, and he had not resumed the habit. While the man was walking about wearing the belt the visiting Commissioner was Mr. Cleaton, who remarked "I am glad to see it, and glad to see you have the courage to do it." The other case was that of a girl who flew at the nurses from behind, caught hold of them by the hair and pulled them down. She wore a jacket with the sleeves down to the elbow sewn to the side

and was thus completely broken of the habit. It was a remarkable fact that the means of restraint used in both these cases was now absolutely illegal, and it would be necessary to put on a strait-jacket, which entailed a great deal more restraint than that adopted. According to these new rules, if a patient was put in a strait-jacket he must be visited every few hours by the medical officer. As far as his experience went, such cases chiefly required restraint at night. Was the medical officer who had a case or two of this kind to be rung up every two or three hours during every night? That would have to be done to conform to the rules, and rendered it impossible to apply restraint when most required.

Dr. BENHAM wished to congratulate Dr. Deas upon the very able way in which he had brought the subject forward, and to say he thought they were all generally in agreement with him that mechanical restraint was occasionally useful. They would all probably admit that in public asylums like his own they had very much less occasion for it than in private asylums; but they had to use it occasionally, and he had had two or three cases in which the patient's life was saved by mechanical restraint having being used. Dr. Benham mentioned a case in which a woman had put her hand into her vagina and torn it out. His colleague, Dr. Aveline, succeeded in patching the parts together. The woman was restrained for some weeks afterwards, and eventually recovered. They had other cases, such as face-picking, partly restrained by means of gloves. Some had recovered, and others had proved intractable. But while he was in favour of mechanical restraint he thought it ought only to be used under stringent medical supervision. With regard to what Dr. Wade had said about supervision at night, he supposed every Superintendent would use his own discretion. If a very bad case was under treatment probably the assistant medical officer would see the patient as late in the evening as possible, and the case would never be left by the nurses, who would report anything exceptional at once. In the ordinary course, without such a report, the case would not be seen again until next day. He did not think human nature could tolerate constant visits during the night. He had been particularly interested in what Dr. Weatherly had said about Dr. Langdon Down's treatment. His method of treatment was practically that the patient should be accompanied everywhere, especially to the water closet, and that ice should be kept at hand and applied at once to the part affected as required. Dr. Langdon Down had told him that he had successfully treated many cases in that way. One of the means used by him was to provide strong huckaback drawers, constructed on the principle of children's drawers, without an opening. These they had found a very effective means of stopping the habit, but, of course, in a public asylum they were at a disadvantage, as they could not give that individual care and attention which could be obtained in private asylums. It might be said for most of them, however, that they did the best they could to restrain habits of the kind mentioned. When nurses and officers found that mechanical restraint saved trouble, they would be found willing to adopt it, and for a long time to come it would probably be difficult to avoid extremes, so that a wise and efficient supervision was necessary. At the same time, as far as he could see, until some new method of treatment arose, they would require to use mechanical restraint in rare and difficult cases.

Dr. MACDONALD did not think there was much difference of opinion with regard to these exceptional cases, but he still was strongly of opinion that the less restraint they used the better. He was quite certain they were influenced by representations from the staff, and sometimes very justly so. They expected to get faithful reports from their nurses and attendants, and he knew from his experience that if they had a leaning towards the use of exceptional means, the medical officers would occasionally be moved, even against themselves, to adopt it. All the time he had been in the present home of his labours he had only once used mechanical restraint for any length of time. In that case an ordinary long-sleeved jacket was worn for the prevention of self-abuse. He would not use mechanical restraint in cases of dirt and rubbish-eating. The nurses and attendants ought to be able to prevent that if they were doing their work. But Dr. Deas, although putting the case strongly, had so

guarded himself by pointing out the errors and dangers, that there was little upon which they could disagree and he most heartily seconded Dr. Benham's expression of thanks for his so ably bringing the subject before them.

Dr. ALDRIDGE said the cases that had been brought before them were certainly very exceptional. He had only one entry in his restraint book in five or six years. That was a case in which he had to use a sleeved jacket on three or four occasions, for face scratching. The old lady so treated occasionally became very violent and scratched her face until the blood ran down in streams, and there was a terrific struggle to prevent her self-inflicted injuries. The sleeved jacket, however, enabled her to walk about for two or three hours till the attack passed off. He remembered having a case fifteen or sixteen years ago, who was dreadfully suicidal. She was restrained in the same way so that she could more easily be managed. The third case that occurred to him was the wife of a sea captain, who had thrown her child out of a port-hole. She was very homicidal, and her husband had devised a form of restraint which she wore as a muff, there being straps under. She brought this with her, and on two or three occasions when she felt the tendency coming on she begged to have it put on, and it was put on for a few hours. She afterwards went to a county asylum, and he did not know what had become of her since. Patients were actually grateful for being restrained. One of the cases he mentioned proved that.

Dr. DEAS, in reply, said that he had been under the impression for many years that it was one of the most difficult things to restrain a man from masturbation by mechanical means. There had been all sorts of ingenious devices, quasi-surgical, &c., suggested for the purpose. He could not see how wearing long-sleeved jackets would prevent a man from masturbating. The patient would turn on his face and effect his purpose. How would that be stopped?

Dr. WEATHERLY said the man could be turned on his back at once if the case was always under observation.

Dr. DEAS could quite understand that, but he at first gathered from Dr. Weatherly that he was of opinion that mechanical restraint alone would prevent it. That was quite contrary to his experience, and that was why he did not allude to it. With regard to women, he had been only stating his own experience, but perhaps it ought to be taken into account that the cases in which he had used mechanical restraint were not so much the chronic cases as those acute outbursts which occurred especially in young girls and puerperal cases, and his experience was that in those cases the hand was the offending member, and that if the hands were confined they practically stopped it until the period of excitement was over. He was rather inclined to agree with Dr. Weatherly with regard to the cases of extreme restlessness at night. As to what Dr. Macdonald had said with regard to the staff, he thought they would be placing themselves too much in the hands of their officers if it was recognised that mechanical restraint would be applied if only a strong enough report was made. A remark by one speaker led him to add that he thought he had not sufficiently emphasised one point, and that was that in some of these cases it was necessary to continue the treatment for some time. They must persevere and not be discouraged after a short trial, and in a great many instances they would succeed with cases which at first seemed practically hopeless.

CLINICAL NOTES AND CASES.

*A Medico-Legal Case.** By BONVILLE B. FOX, M.A., M.D.
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I venture to take up your time with a brief recital of this case for two chief reasons: (1) That its diagnosis was not too clear from a purely medical point of view, and (2) that grave legal consequences depended upon the acceptance or rejection of that diagnosis as correct. At the outset I confess that my view was decisively rejected. We all of us learn more from our mistakes than our successes, and I will try to tell the story as concisely as I can, and ask you to decide whether I was right or wrong, or how far the patient was responsible.

In the spring of this year I was asked to see this case in the county gaol under the following circumstances:—Some three weeks before my visit he had been committed for trial to prison on the charge of obtaining goods by writing a cheque on a bank in which he had no account. His family thought he was so much safer there, that they had not asked that he should be admitted to bail.

This was his history. He was a man of between 50 and 60, a retired army officer, who had served with some degree of distinction a good many years ago. He was married, with a grown-up family. Several years before some transient mental disturbance, apparently of a maniacal character, had occurred, but he had been well a long time. He had utterly come to grief in money matters, however—had been adjudicated a bankrupt, and what is more, and a point of some importance in the case, had never obtained his discharge. For several years past he had been living with his wife and family, but in consequence of his peculiar pecuniary position, any participation in the management of the household had been denied him, and he had only been given a few shillings weekly to spend by way of pocket-money. He occasioned no trouble, and for years had been sober, orderly, quiet, and affectionate, and a decent member of his family and society. A few months before I saw him, a well-meaning friend thought it would be a good thing to get him an employment which would give him a useful occupation and bring him in some money, and accordingly procured for him an engagement as a commission-agent to sell safes. And this was the beginning of the trouble. He had not long been so employed before his friends noticed a change

* Read at the Annual Meeting British Medical Association, London, 1895.

in him. He became agitated, restless, and excited, and though he sold but few safes, he began talking of the wonders he was going to do in his new line, and of the amount of money he was going to make. He became a perfect curse to his acquaintance in his attempts to push his goods at all times and places, but as, perhaps, that is only the characteristic of a good commission-agent, I will lay no stress on that point. Things soon went beyond that, however; he woke early in the morning, not only could he not sleep, but he could not stay in bed, getting up and ringing the bell for the servants at the most unreasonable hours, even when staying in other people's houses, and running up and down stairs.

Then an emotional change was observed. The kind, gentle, courteous husband became transformed. He ceased without reason to care for his wife, or to show any consideration for her health, which had been weak for years. He grew noisy, wild, and excited when with her, utterly callous to her suffering, and finally proceeded to such extremes, and used such foul language, that he had to be excluded from her room.

Then extravagance in deed as well as in word appeared. He dressed in an extraordinary and noticeable manner. He bought all manner of unnecessary things, and launched out into expenses which he had no means to meet, and incurred useless debts which any ordinary person in his position as an undischarged bankrupt must have known would have brought him within reach of the criminal law.

Then arose significant symptoms of a sexual type. He indulged in open and unblushing immorality. He publicly consorted with a woman of doubtful morality; he asked both her and one of his domestic servants to marry him, and actually invited the former to the house where his wife was living. Though already married, he advertised for a wife; he proposed to the chambermaid at an hotel whom he had only seen once. Indeed, he did not know her name, and wrote a most silly letter on the subject for the head waiter to give her, as, owing to this ignorance, he could not address it himself.

He was seen about this time by an eminent specialist in London, who, I am informed, told the family that he thought the patient was in the early stage of general paralysis, but that he could not then sign a certificate for his restraint.

His family by some means or other—probably by cutting him off all supplies—got him to go and live in a country doctor's house, and he went on a little better for a time, but still showed extravagant ideas—bought, as he thought, a horse—and after a time refused to stay any longer, but not before he had convinced the doctor of his insanity. Then, as a last resource, and because there still seemed to be a difficulty about certification, the family determined to ship him abroad, and it was, indeed, for the ostensible payment of some wholly unnecessary articles for his

outfit ordered by himself that he uttered this cheque and was arrested.

Such, gentlemen, was the history that was given me, partly from interested sources, it is true, but I have no reason to doubt its correctness, which was, indeed, fully borne out by a large number of the patient's letters. On that history, I gave it as my opinion that he was insane, and in all probability suffering from the early stage of general paralysis.

When I saw him three weeks after his committal and incarceration the restraint and quiet of prison appeared to have exercised a beneficial and calming effect. But he seemed unable to appreciate his position, and while practically admitting the correctness of the statements made to me, he accounted for most of them by saying that they were caused by the interference of relatives, and by his being tied in London, which he hated. He assured me that he had committed no offence against the bankruptcy laws, because he could have got his discharge at any time, and he did not seem able to discriminate between what he could do, (according to his account), and what he actually had done. Similarly, he excused his having uttered his cheque on the bank by his belief that an account was going to be (not had been) opened for him. For some of his actions, the sexual especially, he could give no reason or excuse whatever; and his reasons, when given, were really no reasons at all, so silly and puerile were they. All through a long interview he was casual and indifferent to his position to a very remarkable degree. He betrayed no anxiety as to the event of his trial, and showed much more concern over a trifling tumble that he had had than over his incarceration. He had employed his time in prison in reading magazines and in making fancy sketches, chiefly of girls' heads.

The physical signs of the suspected disease were nearly all in abeyance, save that he was ill and cachectic looking to a degree that could not be accounted for by his short imprisonment. The skin of his face was conspicuously greasy, and the malar capillaries congested. But I did not consider that the absence of physical signs negatived the existence of general paralysis, especially in an early stage, and where the patient was free from excitement of all kind. I therefore stated that there was nothing in my interview inconsistent with the conclusion suggested by his history, though I was bound to add that apart from that history I could not have signed a certificate as the result of my visit.

The trial speedily came on at the ensuing Quarter Sessions, the patient remaining in prison the while, and his condition much the same. Different friends and relatives testified as to the marked alteration in conduct, habits, appearance, and emotions. The women he had offered to marry told such ludicrous stories that the whole Court laughed, and when the jury interposed and said they

wanted to hear no more such evidence, but the medical witnesses, I fondly imagined they were convinced as to his irresponsibility. The doctor in whose house he lived testified as to his belief in his insanity. I stated my opinion. The cross-examining counsel was very courteous, but his first question was whether, of course, I was aware that the legal and medical professions unfortunately took different tests for responsibility and views thereon. As I anticipated, much stress was laid upon my inability to sign a certificate as the result of my interview—apart from the history—as to the *then* insanity of the patient, three or four weeks after the important date when the offence had been committed. I was asked whether, in my opinion, when he committed the offence he knew the difference between right and wrong? With a clear conscience I replied that I did not think he did, for whatever the answer was worth. The gaol surgeon was then called to give rebutting evidence, and stated that, in his opinion, the prisoner was responsible.

Against the Chairman of the Court I have not a word to say personally. He is a most estimable country gentleman, univerrally and deservedly popular, experienced and esteemed in his magisterial position, and, though reputed to be lenient, yet meting out justice with fair and equal hand, and ever desirous to get at the truth. And I think it was this anxiety to be fair that unconsciously biased him against the prisoner, a man of his own social order and rank. For I am bound to say that his summing-up struck me as prejudiced and unfair. He prefaced it by saying that he did not know that he had ever had before him so difficult a case, from which I inferred that perhaps it might be his first case in which the plea of lunacy was raised. He then went on to tell the jury that the law undoubtedly was that unless at the time of the commission of the crime the prisoner was unable to tell the difference between right and wrong he must be held responsible. Further, "that Dr. Fox was asking them to do what he declared himself unable to do himself, viz., to give the prisoner a certificate of insanity." What I had sworn distinctly was, that from the history and symptoms of the prisoner I believed him to be insane at the time the offence was committed, though when I saw him nearly a month afterwards, during which time he had been under restraint, I could not have then signed a certificate. The jury promptly convicted the prisoner without leaving their box, and he was let off with six weeks' imprisonment. The prisoner received his sentence with the same air and demeanour he had maintained through a long day's trial, and which may be described as the utmost indifference as to what was going on around him.

Such, gentlemen, is my medico-legal case. One of no great importance as regards the gravity of the offence committed and penalty inflicted, but involving a punishment

of incalculable weight and bitterness to the children and near relatives of the accused.

The questions it suggests are two.

1. Could such a combination of symptoms be consistent with sanity, and was it not extremely suggestive of general paralysis? Does not the subsequent apparent improvement rather confirm than weaken such hypothesis? Do we not all see cases of general paralysis admitted into our asylums, which after restraint and quiet subside for a time, so that it would be extremely difficult to certify them?

2. Was not the question left to the jury and test proposed to them an utterly fallacious one? The "knowledge of right or wrong!" Can we, as practical physicians, say one word in its favour? Surely it is only in exceptional cases—of which I believe this to be one—that such knowledge is obliterated. And though happily now many of our judges take a more enlightened view, one more in accord with the advancing knowledge and science of our times, is it not a shocking thing that still from the Bench we sometimes hear this ancient formula proposed, and justice thereby converted into its travesty? That this may be done by men entirely conscientious, and in common matters of daily life shrewd and long-headed, makes it all the more objectionable. So long as such a possibility exists, can we, dare we, say that there is no need of any alteration in the questions left to the jury in these cases of criminal responsibility, no need of some better agreement between the legal profession and our own? If wisdom is to be justified of her children, we should spare no pains in bringing the judicial and the public mind to a better understanding in this particular, and should shrink from no effort towards the complete demolition of this temple of prejudice and ignorance. The desire, gentlemen, to have contributed, however little, to so happy a result, must be my excuse for the demand I have made upon your time this morning.

NOTE.—It is necessary to state that within 48 hours of having uttered the cheque the prisoner showed symptoms of uneasiness and tried to get it back. But this paper is not based upon his knowledge of right and wrong, whether perfect or imperfect, but its aim is to show an example of this deceptive test as to criminal responsibility being left to an English jury within the last few months.

It may be added that since his liberation his wife died, and that the event moved him not at all. He has continued his wild and reckless conduct, and has now been shipped off to the colonies.

Dr. HUGHES (St. Louis, U.S.A.)—We had supposed on the other side that the “knowledge of right and wrong test” had been abolished in England ever since the famous trial of Hadfield for shooting at the King in Drury Lane. In our country we are accustomed to point to British advance in medico-legal affairs on the line of enlightened humanity in accord with the dicta of psychiatric science that insanity is a disease which may co-exist with a knowledge of right and wrong, modified, of course, by disease, though not always apparent in any specific act.

*Notes on Three Cases of Spontaneous Gangrene.** By W. B. MORTON, M.B.Lond., Assistant Medical Officer, Wonford House, Exeter.

Gangrene is undoubtedly a rare occurrence amongst the insane, although one would expect the lowered vitality and diminution of general sensibility, which are found in many mental diseases, to be predisposing agents, and it is a remarkable coincidence that we should have had three cases within nine months amongst less than 150 patients.

CASE I. was that of J. T., a fat, flabby, unhealthy man, aged 52, who was admitted on 22nd August, 1894, with an attack of recurrent melancholia. He was restless, sleepless, refused all food, and had to be fed with the tube.

A fortnight after admission the right foot was noticed to be swollen, cold and discoloured, and this became worse, until at the end of a month the toes were black, dry, and shrivelled, and a line of demarcation was formed at the ankle-joint; his general health was poor.

At the end of two months he was much improved, both mentally and physically; he was rational, but still melancholic; he ate well, and was much stronger; there was a well-marked line of separation at the ankle-joint; shooting pains in the foot and leg were severe, but were controlled to a great extent by opium.

Six weeks later his health had further improved, and consequently the leg was amputated at the “seat of election.” Recovery after the operation was uninterrupted, and in a fortnight the stump was soundly healed, but the shooting pains and painful sensations

* Read at the Quarterly Meeting of the South-Western Division, at Exeter, 1895.

in the missing toes remained for several weeks; he continued to improve, both mentally and physically, and after nine months was transferred to another asylum.

CASE II., M. K., an American lady, aged 76, who was admitted on 18th September, 1894, with an attack of acute mania.

During the first week she was sleepless, and at times violent, refused food, and had to be fed with the tube; her general condition was poor, there being much cardiac weakness and irregularity of pulse. At the end of the week the right foot and leg were found to be colder than the left and somewhat swollen, and three days later there was marked discoloration, extending to 6in. above the ankle, and a brawny swelling was noticed on the posterior surface of the leg, reaching to within 3in. of the knee.

At the end of a month her mental condition was much improved; she could talk rationally, but there was still some mental confusion; the foot was black, dry and shrivelled, and there were several large bullæ on the leg; the brawny swelling was increased in size, and was tender and painful, but as yet there was no sign of a line of demarcation.

At the end of two months her general condition was much improved; she ate and slept well, and her pulse was stronger and regular; mentally she was almost herself, but at times unstable and suspicious; she complained much of shooting neuralgic pains in the leg and foot, especially at night; a line of demarcation was apparently forming 3in. below the knee in front, and 1½in. behind.

A week later the leg was amputated through the condyles by a modified Carden's method. There was considerable shock for 48 hours; she was drowsy and at times delirious, but she rapidly recovered, and 12 days afterwards she was quite herself and the stump soundly healed.

Subsequently she had two relapses, but finally was discharged recovered on April 9th, 1895.

Painful sensations in the missing toes persisted for five months, but gradually died out.

CASE III., M. B., a very stout lady, aged 69; she had been insane over 30 years, and was suffering from dementia, with recurring attacks of excitement. During the last few years she had several severe attacks of faintness and dyspnœa, resulting probably from a fatty heart.

On May 1st she was suffering from diarrhœa, and was confined to bed for eight days, and was much weakened in consequence; she then became excited, and was allowed to get up, and a few hours afterwards complained of sudden severe pain in the left leg, and returned to bed. Next day the foot and leg were cold, swollen and tender, as far as the knee, and there was commencing discoloration of the foot, which rapidly spread upwards without showing any tendency towards a line of demarcation; her general

health was very bad, the heart was dilated and fatty, and the pulse rapid, irregular and feeble; the gangrene continued to spread up the thigh. the cardiac condition became gradually worse, and she died 12 days from the beginning of the attack.

No post-mortem was allowed, but an examination of the femoral artery, below Poupart's ligament, showed it firmly plugged by clot, and during life there was marked tenderness, and an impression of solidity along the course of the vessel.

The cause of the gangrene in J. T. was probably thrombosis of one of the chief arteries of the leg, the contributing factors being (1) a weak fatty heart, (2) disease of the arteries, as shown by examination of the removed portion of the leg, and (3) the lowered vitality resulting from his weak general condition, refusal of food, and constant standing on the cold floor during restless sleepless nights.

In M. K. there was probably a similar origin, though there was no ascertainable disease of heart or vessels. She was in a weak state of health from the refusal of food and exhaustion consequent on the mental disease, but there might have been some slight direct injury received during one of her violent outbursts.

An examination of the removed portion of the leg showed the brawny swelling referred to above, to be a cellulitis spreading inwards between the superficial and deep muscles; there was a tendency to breaking down in places, but no pus was present.

It seems possible that the gangrene was produced by the spread of inflammation to the arteries from the cellulitis, which was probably caused by some direct violence to tissues of lowered vitality, although the discoloration of the gangrene was distinctly prior to any tangible cellulitis.

The *third case* was probably of a different nature and due to embolism, the heart was fatty and dilated, and it is likely that during the week's illness in bed, a clot was formed in the heart and became dislodged when she got up, causing the sudden and severe onset of the disease.

It was noticeable, as is so often found in mental diseases, that in the first two cases there was marked improvement in the mental symptoms within a day or two of the onset of the physical disease, especially in M. K., who quickly passed from noisy incoherence and violence to comparative quiet, and rationality, and she continued to improve as the disease advanced.

Discussion on Dr. Morton's Cases.

Dr. DEAS said he had been in practice in this specialty for thirty years, and these were the first cases he had seen of the kind, and they had all occurred within nine months as Dr. Morton had pointed out. Doubtless, Dr. Morton's modesty had prevented his saying before them what he (Dr. Deas) would like to say, and that was that the very satisfactory result in the first two cases was undoubtedly due to the very skilful manner in which he treated them.

Dr. AVELINE mentioned a case of gangrene of the foot, and Dr. WEATHERLY referred to another of slight gangrene who gradually recovered.

Drs. DAVIS and ALDRIDGE also cited cases of gangrene of the toes requiring amputation.

Types of Traumatic Insanity. By THOMAS PHILIP COWEN, M.D., B.S. (Lond.), Assistant Medical Officer, County Asylum, Prestwich, Manchester.

Several cases of *insanity following injuries to the head* have been admitted to the County Asylum, Prestwich, of late. Although we do not assert that there is a special form of insanity arising from "trauma," yet there are certain *types* of mental derangement produced either directly or remotely by injuries. The five cases which are described below are of special interest and are good examples of certain of these types. None of them proved fatal, but the diagnosis is so clear in each of them that the pathological processes involved may be accurately described.

The second and third cases have recovered and will probably do well. The first, fourth, and fifth are apparently hopeless, and will probably remain in much the same condition for the rest of their lives.

The depressed fracture causing the epileptiform seizures in the fifth case could not be treated surgically, as operation was refused.

CASE I.—*Imbecility with Epilepsy, arising from Injury during Birth.*—J. R. S., aged 26 years, was admitted to the asylum on 12th July, 1895.

Family History.—He is the eldest of a family of six. The remaining members of the family are quite healthy, mentally and bodily; none have suffered from fits or paralysis of any kind. He was born after a prolonged and rather difficult labour, but one which did not necessitate instrumental interference.

During the first few months after his birth nothing special was noticed, except that he did not develop properly and that the legs seemed weak, although not limp and absolutely parietic. The child was said to be always fretful and restless, and showed a

tendency to twitchings of the limbs. He was very late in learning to walk.

During the next two or three years he seemed dull and imbecile in manner, and lacked the ordinary childish interest in, and power of investigating his surroundings. Definite epileptiform fits began at about four years of age, and are said to have affected the left side of the body first. He had usually three or four fits in a week; none of the fits were followed by paralysis. As he grew older he became querulous, excitable, and at times violent after the fits, and for that reason he had to be removed to the asylum. Childish and simple-minded, he could never be taught even to read or write.

On Admission.—A rather thin, ill-developed, weedy young man of 5ft 4in. in height, brown hair and beard. Has but little expression in his face, and is apt to laugh and cry alternately for any trifling cause. He has a smallish rounded head, but without asymmetry, narrow forehead, or vaulted palate. Has slight varying degrees of internal squint in both eyes, but not permanent. Hypermetropic. The thoracic and abdominal viscera are normal.

Nervous System.—There is decided weakness of the left arm, left side of face, and of both legs, but more markedly of left leg. The weakness of legs is shown especially when he walks, with a stumbling, stiff gait, and a tendency to scrape the toes along the floor. The rigidity is, however, but slight and does not apparently affect the left arm. The tongue is protruded straight. He shows no mobile spasm. Slight general inco-ordination. There is a slight but distinct diminution of size of the left arm and leg as compared with the right. No affection of sensation, other than a delayed reaction time. Pupils equal, of medium size, react fairly well to light and accommodation. *Fundi* normal. The knee-jerks are both brisk, but especially so on the left side. No cloni obtainable.

Head Measurements.—Circumference: Above ears and over occipital tuberosity, $20\frac{1}{2}$ inches. Transverse: Tape measurement from ear to ear, $11\frac{1}{2}$ inches.

Mental Condition.—He is imbecile in manner and speech. Cannot give any coherent account of himself. Knows his name, but cannot tell his age or anything else about himself. His memory is very poor, and his powers of apperception are small. Smiles fatuously when addressed. Is clean and fairly tidy. Can feed and look after himself fairly well.

Since admission he has had several fits of an epileptiform type, and the initial spasms of which always start in the left arm and leg before spreading to the other side. Consciousness is nearly always lost. He is liable to become bad-tempered and pugnacious a few hours after each fit, but is usually easily manageable. No increase of the palsy after the fits has been observed.

CASE II.—*Acute Mania a potu, Excited by Concussion of the Brain*

and Spinal Cord.—A. B., aged 33 years, a carter, was admitted to the asylum on 2nd August, 1893.

Previous History.—Has always been healthy up to the present illness. Has drunk heavily for some months. Has never had delirium tremens. Ten days before admission he tripped and fell down several steps when trying to go upstairs, striking the back of his head. He became unconscious, and remained so for a few minutes. He soon recovered his senses, and beyond complaining of pain in head and back and a slight "deadness of legs" he seemed all right until the next day. On that day he became noisy, restless, and acutely maniacal. There were no signs of fracture of skull. Had received a small superficial lacerated wound in occipital region, and some tenderness and bruising was noticed in lower dorsal and lumbar regions.

On Admission.—A well-made, muscular man, suffering from acute mania with incoherence. He evidently has pain in the head and in the lower part of the back, as he winces whenever he is moved.

With the exception of a small superficial suppurating wound over upper part of occiput there are no signs of injury to the skull. He has considerable rigidity over the lower dorsal and lumbar region, but there is no evidence of any fracture of the vertebræ.

Slight pyrexia; 100·4° F. on admission, and for the first three days of his stay.

The thoracic and abdominal viscera are normal. Tongue dry and furred; appetite poor; bowels constipated.

Nervous System.—He does not use his legs well, although he can stand and walk with difficulty, as his legs seem heavy and paretic. Knee-jerks are present on both sides, but are feeble. It is doubtful whether there is any anæsthesia, as it is difficult to arrest his attention.

Pupils equal and react well. No intolerance of light.

Mental Condition.—He is restless and noisy; sings and shouts; gesticulates wildly. Is at times very abusive. Has many transient delusions, chiefly of exaltation and of persecution. He evidently hears voices, and he converses loudly with the imaginary people who surround him. He cannot give any coherent account of himself. Sleeps badly. He remained in much the same condition for about a fortnight, when he slowly began to improve. As the excitement calmed he became more and more sensible to external conditions, and the signs of injury to the spine became more apparent. Pain, fixed and radiating down the thighs, was much complained of, and the inability to properly use his lower extremities was evident.

Some rigidity of thigh muscles, causing cramp-like pain, was experienced. Later there was distinct wasting of the thigh muscles, and especially of the calf muscles of both legs. The

knee-jerks later showed a tendency to become increased. No cloni at any time.

All his symptoms, both mentally and bodily, gradually disappeared, and he was discharged recovered on September 17th, 1893, still, however, having slight weakness of legs when he left the asylum.

CASE III.—*Sub-acute Mania following Concussion of the Brain, with "Contre coup" Laceration of Cortex.*—J. W., aged 54 years, labourer, was admitted on 15th August, 1895.

Previous History.—His previous health had always been good. His wife says that he was "all right" before the accident, and was always bright and intelligent. A month before his admission to the asylum he fell down the opening of a "lift" on the third story of a mill, and is said to have fallen to the ground below, striking the back of his head as he fell. He remained unconscious for some minutes, but was dull and semi-stuporous for the next two days. As the depression passed off he became violent and maniacal, shouting and raving. Had to be restrained in order to prevent him from injuring his friends. There were no evidences of fracture of skull.

On Admission.—A thin man of medium height. Greyish-brown hair and beard. Dull, heavy aspect. Has a small superficial suppurating wound $1\frac{1}{2}$ inches long over the posterior part of right parietal bone. Has two small sub-conjunctival hæmorrhages in left eye, one recent and one old, at outer margin of cornea.

Nervous System.—There is a slight but well-marked right hemiplegia, involving the tongue, face, arm, and leg. The affection of tongue is especially marked. He can use both the arm and leg, but clumsily. Gait is tottery and inco-ordinate. The left side is unaffected. No oculo-motor paralysis. Pupils equal, and react well to light and accommodation. Vision = $\frac{6}{9}$ Snellen. Colour vision normal. Slight deafness of left ear; watch is heard only at three inches. Fundi oculorum normal. Membrana tympani normal.

No anæsthesia. Superficial reflexes normal. Knee-jerks very brisk on right side, normal on left. No cloni. There is considerable motor aphasia, his speech being very elisive and indistinct; it is difficult to make out what he wishes to say, as his utterances are a jumble of meaningless words and sounds.

Mental Condition.—He is restless and unsettled. Is continually undressing himself. It is difficult to arrest his attention. He keeps up a continual chatter of a "verbigerative" type. He apparently hears "voices," as most of his chatter is directed apparently to some "imaginary" person. Is restless and often sleepless. He has to be dressed and fed. He is clean in his habits.

Thoracic and abdominal viscera are normal.

During the next month he began to regain his power of speech, and was able to say simple words and sentences quite plainly. The hemiplegia remained much as on admission.

October 15th.—The paralysis of the arm and leg has almost disappeared, there being only a slight weakness of the right arm. The facial and lingual palsy is unaltered. He can now speak quite well, and seems to have no difficulty in finding the right words. Mentally, he is much brighter and coherent. Is quiet and is doing a little work. The improvement was maintained, and his memory and intelligence gradually improved, so much so that his friends at the end of October said that he “was quite his old self again.” He was discharged recovered in November, 1895.

CASE IV.—*Chronic Confusional Insanity following Concussion from Depressed Fracture of Skull.*—J. L., aged 45 years, an iron-dresser, was admitted to the asylum on 19th August, 1895.

Previous History.—Has never had any illness. Is said to have been quick and intelligent. On June 25th, 1895, when engaged in his work at the foundry, he slipped and fell from a height of about 14 feet, striking his head on some scrap iron. He sustained a severe compound fracture of left parietal bone of a “gutter-form.” He was removed unconscious to the local infirmary, where he was trephined, and the depressed bone elevated as soon as possible. The wound healed by first intention, and surgically the case was most satisfactory. After he had recovered from the immediate depressive effects of the concussion he became restless, noisy, and could with difficulty be kept in bed. He was very incoherent and confused, and used often to shout loudly for hours. He heard “voices” at this time. He became so troublesome that he had to be removed from the hospital to the asylum at Prestwich.

On Admission.—A short, slight man, in feeble health and condition. Brown hair; grey eyes; very dull, fatuous look. Has a recently-healed scalp wound scar running diagonally across left parietal region. Over the middle of this bone is a V-shaped shallow depression in the skull, with rounded smooth edges. This depression is quite behind the motor area of the brain. Pulsation of the brain can be felt in the centre of the depression where the depressed fragments have been removed.

He has a well-marked accessory auricle over middle of anterior border of left sterno-mastoid in line of fourth brachial cleft; the thoracic and abdominal viscera normal. Urine acid, 1018; no albumen or sugar.

Nervous System.—He has no definite paralysis. His muscular power is a good deal enfeebled, but generally, from debility. Sensation is everywhere much dulled and delayed; no oculo-motor paralysis. Pupils equal, 3 m.m. in diameter, and react well to light. Vision is apparently normal. No hemianopia. Fundi ocul. are normal. Both knee-jerks are brisk, but especially right one. No ankle or knee cloni. Superficial reflexes normal. Mentally, he is extremely confused; he mutters to himself or converses with imaginary people who are round him. At times, however, he becomes very excited, rushing about the ward and shouting loudly under the influence of hallucinations of sight and

hearing. He does not seem to understand when asked a question, but stares vacantly at the questioner and mutters vaguely and confusedly. Is restless and sleepless; is wet and dirty in his habits. Has to be fed and dressed. Temperature 98.8° on admission, but rose to 101° on evening of the second day after admission, but returned to the normal range the next morning.

September 5th.—It is noted "that he is still extremely confused, but is more talkative. He keeps up a continual incoherent chatter. He answers more readily, but his conversation is a jumble of apparently disconnected ideas. He is putting on flesh, and is now able to feed and dress himself. Is cleaner in his habits."

October 25th.—He has become quite stout. Is able to look after himself entirely. His face has very little expression. He is jovial, talkative, and boastful; brags loudly of his personal powers and of his property. The confusion of ideas is still very extreme. He cannot remember any recent events at all; his memory is very hazy as to the events which led to his coming to the asylum. When asked how he got his head injured he says that "he was struck on the head a week ago by the little doctor in spectacles with a loaded stick in McGuinness's Singing Hall." He cannot understand where he is; persists that he is in an hotel at Bolton. Thinks he has lost some of his money and valuables, and searches continually for them. There are no paralytic symptoms, either of motion or of sensation. Pupils are equal and react fairly well. Vision = $\frac{6}{6}$ Snellen. Knee-jerks are rather brisk; no cloni. His bodily functions are performed normally.

He has shown no sign of improvement therefore, and although such cases do sometimes improve after prolonged intervals, yet there seems little prospect of such a happy ending to this case.

CASE V.—Chronic Epileptic Mania following Depressed Fracture of Vault of Skull.—J. W., aged 56 years, a blacksmith, was admitted to the asylum February 26th, 1892.

Previous History.—When quite a lad, during the Crimean war, he enlisted and served as a private soldier. At the battle of the Alma he is said to have sustained a compound depressed fracture of the skull, inflicted by a blow from a clubbed musket. He is said to have been taken prisoner by the Russians, and treated in one of their hospitals. Nothing was done beyond dressing the wound. Three months later epileptiform fits began, and have continued at varying intervals ever since, the average number being three a month. There is no history of insanity or of epilepsy in the family. He was a patient in the Stafford Asylum in 1887-8 for a few months. The maniacal seizures with mental automatism and homicidal attacks have followed the fits at intervals, and he has been a source of great trouble to his friends. All operative interference had been refused by the patient and his friends.

On Admission.—A stout, well-built, soldierly man. Grey hair and beard. Has an old depressed fracture of vertex, and several scars of sabre wounds on head and right thigh. There

is the scar of an old wound on scalp over a shallow, saucer-shaped depression in skull. This depression is $1\frac{1}{4}$ in. in diameter, situated about an inch behind the centre of a median sagittal line over vertex from the root of the nose to the external occipital protuberance. The depression is not exactly divided by this median line, two thirds being to the right of the median line. The extreme upper ends of ascending parietal convolutions and adjacent parts of superior parietal lobule are probably the gyri involved. The scar is tender on pressure, but firm pressure causes no symptoms. The thoracic and abdominal viscera are normal.

Nervous System.—There is a slight but distinct weakness of the left arm and leg. No other paralysis. Pupils equal and react well. Knee-jerks normal.

Soon after admission he had several severe major fits. The fits were preceded by a well-marked aura, *i.e.*, a painful sensation in the scar over the depression in skull, which increased rapidly in severity until it reached its acme, when he lost consciousness and fell. General rigidity, followed after a short interval by clonic convulsions, ensued. These spasms were always most marked in the legs, the thighs and legs being at first flexed, and then violently extended. These flexions and extensions were of extreme violence. After the fits he became dull and semi-stuporous, the stupor often lasting for 24 hours. At times the stupor was partly replaced by maniacal outbursts of extreme fury, with vivid hallucinations. During this period he “often fought his battles o’er again,” fancying that he was again taking part in the Crimea with disastrous results to anyone who went near him. These illustrations of mental automatism often recurred after the fits, and were of exactly the same character on each occasion. Between the fits he was dull and partially demented. Childish, querulous and vaguely exalted. Was very excitable and bad tempered. No improvement in any respect followed the usual treatment. Any operative procedure could not be even thought of for several reasons, but chiefly on account of the opposition of his friends.

Remarks.—The first case is, we are of opinion, one of birth-palsy with resulting want of development, physically and mentally, arising from a hæmorrhage over surface of the cerebrum. It is one of those somewhat rare cases in which the symptoms are mainly unilateral.

The diagnosis rests between an infantile hemiplegia and a congenital birth palsy. The history shows no evidence of any causative condition—as an acute fever—nor of any convulsion or sudden paralysis which usually are the first signs of a “thrombosis of the cerebral veins” in infancy. An acute cornual lesion also is out of court, as, again, all symptoms of an acute onset are absent, and the slight paralysis is general and is not confined to groups of muscles

as in that disease. The knee-jerks are also exaggerated. On the other hand there is but little rigidity, nor is there any mobile spasm; still, both of these need not necessarily be present, and the whole of the clinical aspect of the case conforms more to the congenital type than to the acquired forms of palsy in early childhood. The vague weakness of the limbs, hardly noticeable by the mother, the tendency to local convulsion at irregular times, and leading up to the well-marked epileptiform fits at four years of age, not followed by any paralysis, and the after history of the case fully confirm this view.

The second case seems an ordinary case of *mania a potu*, but one excited directly by a severe injury to the brain and cord. It might with equal justice be called a case of traumatic mania arising in a man predisposed to mental disturbance by reason of the toxic action of alcohol on the cells of the cerebral cortex. The character of the mental symptoms and the history rather incline us to the opinion that it is a simple mania from drink following injury. The injury evidently produced an ordinary concussion of the brain, and a hæmorrhage into and surrounding the lumbar enlargement of the cord, producing its usual symptoms by pressure and involvement of nerve roots.

The third case is one of traumatic mania excited by the partial laceration of the cerebral substance directly and by "contre coup." It is, considering the damage which must have resulted, surprising that recovery was so rapid and apparently so complete.

The two last cases are examples of mental and nervous symptoms dependent on severe traumatic disease of the brain, with probably resulting meningeal thickening and a slow atrophic affection of the cortex itself.

In the fourth case, where the depressed fracture was satisfactorily treated, all focal symptoms are absent and only the general effects of the brain injury remain.

The last case, that of the soldier, completes the series, and is most interesting with reference to the preceding one. It shows well-marked focal symptoms, with a progressive, but very slow mental confusion and dementia resulting from an unrelieved depression of skull. The well-marked affection of the legs in the convulsive seizures corresponds with what one would have expected from the localisation of the lesion, but curiously there was no sensory aura beginning in the lower extremities.

OCCASIONAL NOTES OF THE QUARTER.

Report of the Committee on Criminal Responsibility.

We believe that we correctly represent the views of the main body of the Association in saying that the most reasonable course to follow in reference to the above report was that adopted, namely, the middle course. Before lending the weight of its authority to a decision upon a matter so important, the Association would justifiably desire that a report upon that matter, adequately expressing the opinion of the Committee concerned in its compilation, should be in the hands of members for full consideration. A proposal to this effect may be said to be the more reasonable, since the main opposition to the finding of the Committee was manifested, not from without, but by members of the Committee itself. The summary rejection of the report, even though the conclusions reached in it be contrary to the expectations of many, would have been an ungenerous return for the patient labour spent upon it by its compilers, whose judgment is at all times deserving of our fullest consideration. At the same time, the ratification of the report involves a change of front on the part of the Association, which, if it is to take place, should be executed in no uncertain manner. It does not appear to us appropriate at the present juncture to comment at length on the subject of the report. We content ourselves with the observation that there is evidently serious matter for discussion when the report declares that, in a criminal trial in which the question of the insanity of the offender is involved, "from the beginning to the end of the proceedings care is taken that justice should be done;" whilst, on the other hand, we find in the discussion upon criminal responsibility at the British Medical Association meeting in August last, strong opinions expressed, to the effect that, in a very great number of cases, injustice is certainly done. Clearly, a greater unanimity of opinion on such a matter is desirable, in the first place; if it be generally agreed that such injustice does obtain, the next step will be to discuss the propriety of attempting to rectify the evil by any more active method than that in operation, namely, the pressure of educated public opinion, as guided by medical science. Already the report has been discussed

at some of the divisional meetings, and at the next annual meeting it will occupy an important place on the agenda paper. It is much to be hoped that a thoroughly representative expression of the present opinion of the Association in regard to this matter may then be obtained, and a definite system formulated for impressing this opinion on the public and the Legislature.

The Matricide Case.

The verdict of insanity, in the case of the boy Coombs, is probably a just and right finding, although, as we point out in our record of the case, "The Times" and other papers evidently do not admit that the evidence of insanity was conclusive. In the case of an adult, similar evidence to that advanced in this case would have been severely criticised, and would very possibly have been rejected as not being conclusive proof of mental disorder. We fear that the unsatisfactory impression is left on the public mind, that the plea of insanity was thus readily accepted, to escape from the unpleasant dilemma of condemning so youthful a minor. This plea is always received with so much distrust by the public that even a suspicion of this kind must be a subject for regret.

Mechanical Restraint.

The evils of wrong-doing are great and far-reaching, and not the least of these evils are the effects of the regulations which wrong-doing calls forth, and which are intended to prevent similar wrong-doing in future. In any case it is difficult to forecast the effect of legislation. It is never certain that legislation will prevent the evil that it is designed to prevent; but we may be confident that, whether it do so or not, it will produce other evils which were neither intended nor anticipated by its authors. The law which forbade the combination of workmen, for example, did not prevent their combination, and was indirectly responsible for many trade outrages. The law which forbids the sale of intoxicating liquors in the state of Maine similarly does not prevent their sale, but indirectly produces much lying and dishonesty.

The regulation on the subject of mechanical restraint which has been issued by the English Commissioners in order to prevent any repetition of the abuse of that form of treatment which occurred in the case of Mr. Weir, at Virginia Water, may or may not prevent such occurrences in future, but it is pretty sure to entail evil consequences which its authors have not foreseen.

The regulation, in so far as it deals with generalities, is unexceptionable. It is essential to the safe employment of any form of restraint that the patient be frequently visited by a medical officer, and that he be kept under continuous special supervision. It is right that the Commissioners should record their opinion that the use of mechanical restraint should always be restricted within the narrowest possible limits. But when they go on to prescribe the precise appliances which alone may be used for that purpose, the Commissioners exceed, in our opinion, their legitimate function, assume a dangerous responsibility, and unduly restrict the discretion of those upon whom the direct responsibility of the care of the insane is cast.

The editors of this Journal, and the Association whose organ it is, have never been advocates of mechanical restraint. They are and have ever been at least as anxious as the English Commissioners to minimise the use of this form of treatment; but they regard the division of responsibility in the treatment of patients as an evil of quite as great magnitude as the excessive use of mechanical restraint. When the discretion of the medical man in charge of a patient is fettered and restricted, so that he is prevented from using a form of treatment which he, with his experience, in view of the special circumstances of the case, and having regard to the current opinion of his professional brethren, believes to be the best, then such a restriction is, in our opinion, unwarrantable.

It will be evident, too, that the regulation of the Commissioners meanwhile prevents the invention of a mode of restraint less irritating or more advantageous to the patient. It may even have the effect of unduly increasing the use of hypnotics.

Holding these opinions, we must regard the selection and sanction by the Commissioners of certain forms of restraint, to the exclusion of all others, as an unwise and regrettable exercise of authority, although we have the

utmost sympathy with the intention to minimise the use and to prevent the evils of this mode of treatment.

The Scottish Board of Lunacy defines restraint as follows : —“ Whenever a patient is made to wear an article of dress or is placed in any apparatus which is fastened so as to prevent the patient from putting it off without assistance, and which restricts the movements of the patient or the use of hands or feet.” Their requirements with respect to restraint are that entries are to be made daily, to be signed by the medical officer who ordered the restraint, who must also give his reason for the order.

Mechanical means of restraint are defined by the English Commissioners as “ all instruments and appliances whereby the movements of the body or of any of the limbs of a lunatic are restrained or impeded.”

The Irish Inspectors in this regulation, as in many others, faithfully copy the English Commissioners.

The Evans Case.

Mechanical Restraint and Breach of the Lunacy Laws.

At the Birmingham Quarter Sessions, on 11th October last, a medical man was fined £50 for having unlawfully taken charge of a lunatic in an uncertified house, etc. The defendant is reported to have stated that “ he kept her in postural straps at intervals for a month, because during that time she scarcely once recovered sufficiently to be released.”

The Recorder, in passing judgment, remarked that he “ was willing to believe that the defendant acted on an honest but ignorant belief, and would not therefore pass on him a sentence of imprisonment.”

This case, in which a doubtless well-intentioned medical man probably narrowly escaped a very serious position by the fact that the patient had been removed to an asylum twelve days before death, is a strong evidence of the necessity of continually insisting on the danger of this mode of treatment. The profession at large evidently needs continually to be reminded of views which, to alienists, have assumed the form of truisms.

The Lanchester Case.

The details of this case have been widely published in the daily press and are fully reproduced in this Journal.

Dr. Blandford, it appears, was called in by the relatives of this young lady to inquire into her mental state, the principal reason for this inquiry being the fact that Miss Lanchester had expressed her determination to live with a man without any marriage contract, and to enter on this connection in the course of a day or so. Dr. Blandford, after an interview with the young lady, signed an urgency certificate of insanity, and her father signed an order for her admission to the Roehampton Asylum, whither she was at once removed by her relatives, not without some struggling and force.

The family doctor visited Miss Lanchester at the asylum, signed a second certificate, and a petition was duly presented to a magistrate, but before he could interview the patient she had been discharged from the urgency order by two of the Commissioners in Lunacy, who had visited Miss Lanchester on the representations of Mr. John Burns and others.

A Lanchester Consultative Committee was at once formed to consider what steps should be taken in the case, and at one of the meetings of this Committee a "legal opinion" is reported to have been read, which is printed in full in our report.

A letter from Miss Lanchester was also read, expressing the view that in face of this opinion legal proceedings would be useless, and up to the present date no legal steps have been taken.

The motives actuating this drama are of considerable interest. In the first place, Miss Lanchester viewed her intended action as a protest against "marriage," which she considered to be "immoral"—a view which she had long held and expressed.

Miss Lanchester's relatives obviously considered her proposed act to be the outcome of insanity by calling in the aid of Dr. Blandford, who states that he regarded the forming such a connexion by an educated lady with a man greatly her inferior in position as practically "social suicide," and he further expressed the opinion that in Miss Lanchester's case it was the outcome of unsoundness of mind, in which opinion he was strengthened by a family history of mental disorder and other reasons which have not yet transpired.

Dr. Blandford, bravely rather than wisely, disregarded

the judicial advice to give judgment, but not reasons, by publishing his views of Miss Lanchester's case. His statement does injustice to himself, from his being unable to exhaustively describe or disclose all the reasons on which he formed his conclusion.

Dr. Finney, Miss Lanchester's family attendant, who has been a medical officer in two public asylums, gave grounds for his certificate differing from those used by Dr. Blandford.

The Superintendent of the Roehampton Asylum, Dr. Chambers, does not appear to have reported her as not insane, and must therefore be regarded as concurring in the allegation of mental unsoundness.

The Commissioners in Lunacy, possibly stimulated to promptitude by Mr. Burns and special editions, having visited and examined Miss Lanchester, came to the opposite conclusion—that she was not insane, and accordingly discharged her, without having heard the history from her relatives or medical attendant.

The actual question at issue, as usual in evening edition excitement, has been obscured. The question has not been whether the holding or the acting on such views in regard to marriage constitutes insanity, but whether in Miss Lanchester's case they were not the outcome of or associated with mental unsoundness.

Gross injustice has been done to Dr. Blandford in attributing the first of these propositions to him—it is one that is quite untenable. In the second (*viz.*, whether these ideas were the outcome of or associated with insanity), even if Dr. Blandford is in error, it must be remembered that he is a man of unquestionable integrity, of extensive experience, and that there can be no question of his good faith; moreover, that he was supported in his opinion by the patient's family, by her customary medical attendant, and probably by the asylum physician.

No question, therefore, can arise of conspiracy, collusion, or other malpractice against the liberty of the subject.

The outcry against the lunacy laws based on this case is obviously misplaced, since it illustrates the promptitude with which a person may be discharged (in any case in which reasonable doubt exists), much more markedly than the undue facility of admission to an asylum.

The protection given to medical men in signing certificates is most forcibly brought out. The opinion drawn up by a barrister and approved by the late Home Secretary, Mr.

Asquith, is most conclusive on this point, and shows that the safeguarding of medical men in the performance of this duty is most complete. No more convincing proof could be given than by the fact that such a committee, formed for the express purpose of legal prosecution, should have been thus completely restrained from taking action.

The duty of signing certificates of insanity imposed by law on the medical profession is probably the most repugnant and objectionable function which a medical man has to discharge. The written disclosure of professional secrets concerning a patient, which in other circumstances would constitute a libel, is utterly opposed to the ethical feeling of the profession, many members of which already decline on this and other grounds to certify insanity. The extension of such a feeling would lead to great difficulty in placing those suffering from this form of disease under appropriate treatment, indeed many instances might be quoted in which it has already been productive of disastrous results.

We must hail with satisfaction, therefore, this proof of the protection afforded by the law to the medical men who undertake this obnoxious function.

A humorous side to the affair is shown in the combination of the "individualists" and "socialists" supporting Miss Lanchester's "protest against marriage." The "reasons" for this community of feeling amongst divergent atoms would be interesting reading. We learn that Lord Queensberry expressed great admiration of Miss Lanchester's conduct, while Mrs. Weldon is reported to have said that she sympathised with the parents.

The case may even yet appear before the tribunals, and we will therefore abstain from any direct expression of opinion as to the question of sanity or insanity. We must, however, reiterate that the allegation of insanity was not based, as a portion of the lay press alleged, on Miss Lanchester's views in regard to marriage, but on the question whether in her case they were associated with or were the outcome of mental disorder.

The Four-Shilling Grant.

We observe that the important question of the Government Grant has been again before the Lancashire Asylums Board. It would appear that the resolutions of the County Councils' Association were in favour of extending the four-

shilling grant to chronic pauper lunatics maintained in workhouse wards under special regulations, and to idiots maintained in public institutions. It was pointed out, however, that there was a material departure from the resolution adopted by the Lancashire Board, which prescribed that, before the grant was to be extended in that manner, the patients must have been treated in an asylum—a period of two years having been mentioned. Thereupon a deputation to the Local Government Board was appointed, and the Lancashire Asylum authorities are to be congratulated upon having made a stand for their own opinion. The treatment of acute insanity cannot be effective under workhouse regulations. An asylum is a hospital, and should receive the mentally-afflicted in the first instance. A workhouse may, under proper authority, be fitted to accommodate harmless demented; and, in the interest of the ratepayers as well as of the insane, such a rearrangement is highly desirable. It is, however, of essential importance that the cases selected for the cheaper, simpler, and less specialised care of workhouse officials should have passed through the local asylum and under the review of the Commissioners. We are not inclined to fix any term of residence in asylums, preferring to leave their physicians unfettered by such a regulation as the two-year limit spoken of at Lancaster. It is quite probable that a very much shorter period of observation would suffice to determine the propriety of passing a hopeless, easily-managed case from an overcrowded asylum to the lunatic ward of the neighbouring workhouse. We need not support these views by lengthy reference to the results obtained in Scotland under such a system as is now recommended, but must congratulate Dr. J. A. Campbell on the eminent success attending the proposal which he brought forward at our Annual Meeting of 1893.

The Increase of the Association.

We do not intend to anticipate Dr. Outtersson Wood in any way. The results of his laborious research into the early history of our Association will be published in the next number of the Journal, and must prove of lasting interest to every loyal member. As it has become necessary, however, to increase the size of the Journal as well as to instruct the printer to produce a larger number of copies, in

consequence of progressive additions to the roll of members, we place on record the maximum attained at the date of last Annual Meeting. There were then 509 members on the list, inclusive of 48 honorary and corresponding members. Ten years ago the total membership was 432, inclusive of 58 honorary and corresponding members.

We look forward confidently to a still further increase, consequent upon the establishment of divisional meetings, where asylum medical officers of all grades can attend with greater frequency and greater freedom. In going so far afield for the next general meeting the Association invites candidates for membership to come forward, and we hope for a long list of names on that occasion, as well as sound scientific work and good-fellowship. The formation of an additional division, of which we have heard rumours, will, no doubt, soon take definite shape.

The Attendant's Handbook.

The new edition of the Handbook, published by authority of the Association, has already been sold out. This shows how urgent was the need for such a manual, and the success attending its compilation must be gratifying to those who gave so much time and trouble to make it a serviceable book. The first edition was published just ten years ago, and 3,000 copies were sold before the end of 1892. The experience gained by the practical work of teaching induced the Association to issue a revised edition in 1893, and many improvements were made in rewriting defective sections, and adding engravings as required. At the last meeting of Council, Dr. Hayes Newington and Dr. Beveridge Spence, who have already done so much to perfect the work, were asked to arrange for the reissue of the work, with some additions, and this new edition may be expected in the course of January, 1896.

A Journal for Asylum Workers.

We understand that proposals have been made for the establishment of a periodical for asylum workers—a periodical which will represent the special interests of asylum officials. It has not been—and we trust that it

will never be—the policy of this Journal to neglect the interests of the insane; and the best interests of asylum patients are so intimately bound up with the best interests of asylum workers that we should fail in our plain duty were we to pass these proposals without a word of encouragement and friendly comment.

It would seem that there are once more three courses open to the parties interested. This Journal might publish as a supplement a sheet of domestic details, notes and annotations on asylum experience, communications from the various classes of officials represented on the staff of every hospital for the insane. Such a proposal has been repeatedly made, and might commend itself to the Medico-Psychological Association, which has already been urgent for the improvement of all classes of asylum workers in its corporate capacity, as well as by the individual efforts of its members. We need only instance the educational scheme, which has animated so many institutions for the treatment of the insane of late years, and the magnificent house for attendants at Prestwich.

Another course suggests itself in enlarging the scope and augmenting the activity of “The Hospital.” The nursing supplement of that newspaper has been open to all who are in any way interested in the treatment of disease, and much might be said for thus drawing the bonds closer between general and special hospitals. We have so often to regret our segregation from the outer world and find such indubitable benefit in mingling with our fellows in such societies as the British Medical Association, that the contact of mind with mind in the pages of “The Hospital” would seem to give promise of good work and mutual advantage.

Lastly, a special Journal might be founded as has been recently proposed. It would certainly reflect the opinions and desires of many who may have felt that the alternatives above indicated do not commend themselves for the special purpose in view. Should this be the outcome of the deliberations now in progress, we cannot but offer our best wishes and lend every encouragement to what is done for the interests we all have at heart.

PART II.—REVIEWS.

*The Forty-Ninth Report of the Commissioners in Lunacy,
England, 20th July, 1895.*

It is somewhat refreshing for once to proceed to an examination of the Annual Report of the Commissioners in Lunacy without having to encounter, at the hands of the lay and medical press, the usual yearly erroneous deductions from the statistical tables therein contained, to the effect that insanity, in its more active phases, is making rapid strides among the populace. When the public can be made to grasp the simple fact, to urge no other just at present, that the Commissioners' figures deal with but a section of the occurring insane in England and Wales, they will probably be led to understand that the proportion of the total number of certified insane to the population, so regularly given by the Commissioners, tends to an utterly mistaken estimate of the prevalence of mental disease. This we have, with other cogent arguments, urged year after year in our reviews of this annual publication, and it must be understood that we deal with the statistical summaries given us officially, in so far only as relates to the number of certified insane.

The total number of persons of unsound mind under the supervision of the Commissioners' Office on January 1st, 1895, was 94,081, an increase of 2,014 over that of the previous year. This annual increase of the reported number of insane shows a marked variation annually, and the average annual increase for the last decade (1,437) falls by 219 below the same average for the preceding twenty years. It is only when, as in 1888 and in 1894, there happens, from some cause or another, to be a sudden excessive increase in the actual number of reported cases, that sensation-mongers spread abroad their alarming and imaginative assumptions as to the fearful increase of insanity in our midst. An additional argument against this hastily-formed notion, that insanity is on the increase, is furnished this year by a consideration of the large proportion of senile admissions among the annual admissions; the Commissioners compute that 14·7 per cent. of occurring cases during 1894 (an increase of 1·5 per cent.) were due to senile decay, and could not, therefore, be classified as cases of insanity in its more active forms. We cannot, however, dwell on this *quæstio vexata* every year; for further infor-

mation we must refer the reader to our previous reviews of this Annual Report.

The actual increase above notified (2,014) is caused mainly by a large increment (2,075, including 11 criminals) in the pauper class, the number of private patients under official cognisance having diminished by 61. This increase the Commissioners note to be fairly general throughout the country, there being but eight union-counties (Cardigan, Carmarthen, Cumberland, Dorset, Monmouth, Oxford, Pembroke, and Westmorland) which showed a slight decrease.

The statistical tables in this year's Report have been supplemented by the inclusion for the first time of a summary of the causes of death during the past year. With this we shall deal later on.

The ratio of registered insane on January 1st, 1895, to the population, estimated, not to the beginning of 1895, but to the middle of the previous year (this occurs throughout all the tables dealing with ratios to population), amounts to 30·95 per 10,000, a differential increase of ·32 on last year's ratio and an average annual increase for the decade of 29·86 per 10,000. It is, however, of very little use or interest to attempt deductions from these figures, for the summary is one, as we indicated last year, of official interest only, showing merely the extent and scope of the Commissioners' duties. The same remark applies to the table giving the ratio of the insane certified during the past year to the population. This for the year is 5·88, or ·11 less than in the year preceding. It will only be when an approximate estimate of the total number of insane (certified and uncertified) deduced from the Commissioners' tables and from successive census reports, compared with the estimated population up to the end of each or the beginning of the next year, can be given, that these figures will be of any value whatever to the statistician.

The ratio per cent. of pauper insane to paupers of all classes is, as we have previously shown, of far greater utility in gauging the probable prevalence of insanity in the kingdom, for the actual pauper population is known and increases fairly uniformly with the estimated total increase of population (remaining in the proportion of 1 to 36 almost constantly), and the number of pauper insane within the Commissioners' cognisance embraces, with but very few exceptions, the total number of pauper insane in the country. We find then that, instead of an increase, a fairly constant ratio is preserved, the proportion per cent. fluctu-

ating round about ten per cent., being now slightly more and at another time slightly less. But there is to be observed, notwithstanding this rational constancy noted during the last few years, a large increase of the insane pauper population on previous decades, and this is no doubt accounted for by increased asylum accommodation, increased appreciation of asylum treatment, and recent lunacy enactments. The number of paupers maintained in asylums, hospitals, and licensed houses reached the total of 62,322 (an increase on last year's total of 1,865), in workhouses there were 16,898 (an increase of but 29), and with relatives or others, 5,869 (an increase of 176). In other words, 73·24 per cent. of pauper insane were detained in asylums (a percentage increase of ·42), 19·86 per cent. in workhouses (a percentage diminution of ·46), and 6·9 per cent. were with relatives (an increase of ·04 per cent.). From this we gather that local authorities show no undue desire to detain the insane in workhouses, as many as possible being relegated to asylum supervision. On another page of the Report, however, we find the Commissioners expressing their regret that no suitable provision is made in workhouses for the reception of harmless insane, many cases in which asylum treatment is almost essential to recovery being crowded out by the accumulation in asylums of chronic demented and others.

The total number of patients resident in asylums, hospitals, and licensed houses on January 1, 1894, was 69,499, an increase of 2,263 on the number in the previous year. The changes that have occurred in various institutions may thus be summarised :—

	County and Borough Asylums.	Registered Hospitals.	Metropolitan Licensed Houses.	Provincial Licensed Houses.	Naval and Military Hospitals.	Criminal Asylum (Broadmoor).	Private Single Patients.	Idiot Establishments.	Total.
Increase ...	2,843	34	—	—	—	—	1	3	2,881
Diminution	—	—	79	221	10	8	—	—	618
Increase									2,263

The number of admissions into asylums, etc., during 1894, exclusive of transfers and readmissions due to lapsed orders, shows a sensible diminution, being less by 171 than in 1893,

or a total of 17,878. The fluctuations in the various institutions for the insane may thus be tabulated :—

	County and Borough Asylums.	Registered Hospitals.	Metropolitan Licensed Houses.	Provincia Licensed Houses.	Naval and Military Hospitals.	Criminal Asylum (Broadmoor).	Private Single Patients.	Idiot Establishments.	Total.
Increase ...	—	—	40	—	48	4	5	—	97
Diminution	11	56	—	175	—	—	—	26	268
Diminution 171									

Transfers are tabulated as usual, though we fail to see the value of such a summary, for the causes of transfer vary between very wide ranges, and the totals given are, therefore, of little practical service. The table merely indicates to us the number of insane whose location has been changed ; it gives no insight into the reason of such change.

Fresh reception orders, owing to the expiry of original reception orders, are still high in number, totalling 101 during the year, provincial licensed houses requiring the most in proportion to the number of their patients, one per cent. having to be recertified. We very much doubt whether this table will ever show much diminution on these numbers, for as time goes on the work of special certification will become more difficult and intricate.

The actual number of recoveries during the year numbered 7,130, an increase on the previous year of 277. This increase occurs mainly in County and Borough Asylums (483), both Metropolitan and Provincial Licensed Houses showing a diminution in the number of their recoveries of 87 and 183 respectively. The proportion of recoveries to the total number of admissions comes to 40·31 per cent., an improved ratio on that of last year, but not, if we accept the Commissioners' basis of calculation, viz., on the number of admissions, as a correct one, so high as in 1885, 1886, and 1891. Many years ago it was shown that to calculate death ratios on the basis either of the total number resident or of the number of admissions was wrong, the proper factor in such rational estimation being the average number resident. We are quite aware that the only correct method for calculating the recovery rates of individual asylums is on the number of admissions in each, for it has been proved that any other

method introduces a fallacy, the average duration of residence in each asylum not being identical, and that thus comparisons as to recovery rates cannot be drawn. But when we take all institutions together and mass the figures into a grand total, this objection, we think, falls to the ground, and the average number resident becomes the fairer and more reliable basis of calculation. If the percentages of recovery on the average number be computed for comparison, we shall find that we can obtain a gradually improving recovery rate showing fewer variations than the Commissioners' calculations would lead us to believe there existed.

Years.	Recovery Rate per cent. to Number of Admissions according to the Report.		Recovery Rate per cent. calculated on Average Number Resident in each Year.	
1885	41.99	Average Ratio per cent. for Five Years 39.84	9.89	Average Ratio per cent. for Five Years 9.60
1886	41.16		9.73	
1887	38.56		9.41	
1888	38.71		9.54	
1889	38.81		9.44	
1890	38.59	Average Ratio per cent. for Five Years 39.46	9.87	Average Ratio per cent. for Five Years 10.12
1891	41.04		10.58	
1892	38.94		10.03	
1893	38.45		9.95	
1894	40.31		10.13	

The recovery rate on the average number resident for the past five years here shows an increase over the preceding quinquennial period of .52 per cent., while the Commissioners' figures, calculated on the total admissions for the same periods, show a diminution in the recovery rate of .38 per cent., and this in the light of improved methods of treatment and improved sanitation we cannot accept as correct.

The actual number of deaths during 1894 numbered 6,553, a decrease on the previous years' death record of 135, the diminution being distributed throughout all grades of institutions. The proportion of deaths to the daily average number resident was 9.32 per cent., a diminution on last year's ratio of .39. This rate has gradually been dropping since 1890, when it stood at 10.14 per cent. of the average number resident.

The Report gives, as usual, a table setting forth the death ratios per 1,000 of certified insane and the death ratios per

1,000 of the whole population for 1893. It would seem a fair summary for comparison were it not that its value is somewhat depreciated by the error before noted—here, however, unavoidable—that the insane death ratio is made up to the 31st December, 1893, while the whole population death ratio is calculated to an estimated population for the middle of the same year. For comparison the former should also be calculated to the middle of the year. We give, as in previous years, a table of comparative death-rates deduced from the Commissioners' tables to show how the insane death-rate tends to approximate to the whole population death-rate as age advances, as well as to demonstrate how much lower proportionately among the insane the female death-rate stands to the male death-rate compared with the whole population female to male death-rate. An inspection of these figures will explain the accumulation of senile cases in asylums and the preponderance of women of all ages in the various institutions for the insane :—

Age Periods.	Death-rate per 1,000 Reported Insane.			Death-rate per 1,000 whole population.			Proportion of Insane Death-rate to whole population Death-rate.
Under 5 {	Males	}	—	{ Males 64·7	}	59·5	—
	Females			{ Females 54·4			
5—9 {	Males 110·4	}	73·9	{ Males 4·9	}	4·9	15·0 to 1
	Females 37·5			{ Females 5·0			
10—14 {	Males 37·8	}	48·1	{ Males 2·8	}	2·8	17·1 to 1
	Females 58·4			{ Females 2·9			
15—19 {	Males 81·3	}	75·6	{ Males 4·3	}	4·3	17·5 to 1
	Females 69·9			{ Females 4·3			
20—24 {	Males 70·6	}	67·8	{ Males 5·5	}	5·3	12·7 to 1
	Females 65·1			{ Females 5·2			
25—34 {	Males 75·5	}	69·8	{ Males 7·4	}	7·3	9·5 to 1
	Females 64·1			{ Females 7·2			
35—44 {	Males 109·3	}	88·1	{ Males 12·7	}	11·8	7·4 to 1
	Females 67·0			{ Females 10·9			
45—54 {	Males 103·7	}	83·4	{ Males 20·1	}	17·7	4·7 to 1
	Females 63·1			{ Females 15·3			
55—64 {	Males 118·8	}	101·0	{ Males 36·0	}	32·7	3·0 to 1
	Females 83·2			{ Females 29·5			
65—74 {	Males 218·4	}	181·0	{ Males 70·8	}	66·5	2·7 to 1
	Females 143·7			{ Females 62·2			
75—84 {	Males 352·5	}	311·7	{ Males 143·0	}	136·6	2·2 to 1
	Females 270·9			{ Females 130·3			
85 and upwards {	Males —	}	—	{ Males 272·4	}	261·0	*1·2 to 1
	Females 322·6			{ Females 249·7			

* Females.

The whole insane death-rate stands to the whole population death-rate in the proportion of 5 to 1, but it is manifestly unfair to include the age periods under fifteen, and with this reservation it may be accepted that the insane death-rate is 3·4 times greater than the whole population death-rate.

The interesting table (XV.) giving the causes of death in the cases of all patients dying in County and Borough Asylums only during 1894 forms a valuable addition to the Commissioners' annual summaries, and we hope it will not only be regularly continued, but also extended to include

Total number of deaths in County and Borough Asylums in 1894, 5,927.	Total number of deaths in England and Wales in 1894, 498,827.*
Of the total number of deaths	Of the total number of deaths
General Paralysis accounts for 20·3 p.c.	General Paralysis †
Pulmonary Phthisis „ 14·6 p.c.	Pulmonary Phthisis accounts for 8·3 p.c.
Senile Decay „ 9·5 p.c.	Senile Decay „ 4·9 p.c.
Pneumonia „ 7·6 p.c.	Pneumonia „ 6·5 p.c.
Epilepsy „ 6·2 p.c.	Epilepsy „ 0·5 p.c.
Exhaustion from Mania } or Melancholia } „ 5·6 p.c.	Exhaustion from Mania } or Melancholia } †
Cardiac Valv. Dis. „ 5·3 p.c.	Cardiac Valv. Dis. „ 1·8 p.c.
Apoplexy „ 2·9 p.c.	Apoplexy „ 3·2 p.c.
Chronic Bright's Dis. „ 2·6 p.c.	Chronic Bright's Dis. „ 1·5 p.c.
Cardiac Degeneration „ 2·3 p.c.	Cardiac Degeneration †
Bronchitis „ 2·3 p.c.	Bronchitis „ 9·8 p.c.
Cancer „ 2·0 p.c.	Cancer „ 4·2 p.c.
Other diseases too numerous to specify } „ 18·2 p.c.	
Accident } Violence } Suicide } „ 0·6 p.c.	Accident } Violence } Suicide } „ 3·8 p.c.
† The figures for these diseases are merged in others and cannot be given separately.	

every variety of institution for the care of the insane. It will be observed on glancing through this table that of the 5,926 deaths in County and Borough Asylums (the total in

* The figures from which these percentages are calculated have been supplied us by the kindness of the Registrar-General, to whom our thanks are due.

another part of the Report is 5,927) more than one-fifth are due to general paralysis of the insane. We append for convenience of reference a tabular statement of the principal causes of death in asylums compared with the percentages of deaths from the same causes among the whole population.

The table (XVI.) dealing with the ratios per 10,000 of the yearly average of the number of insane admitted into asylums in the five years (1889-1893) to the whole population at the time of the census (1891), each classified into groups according to the professions or occupations, appears to us to be quite a useless expenditure of labour, for in the first place the averages of admission for four years subsequent to the census are employed for comparison with the actual general population at the census itself, a peculiar and remarkable mathematical feat, and in the second place the insane considered are only such as come under the Commissioners' notice. The table is apparently inserted for the purpose of allowing inferences to be drawn with respect to the occurrence of insanity in various callings, and we can only warn the student of this report to discard it as absolutely untrustworthy in this respect.

The proportionate occurrence of the various forms of mental disorder appears to be maintained with a fair degree of regularity. Compared with the percentage ratio to admissions for the decade 1879-1888 melancholia shows an increase of 1.6 per cent., and mania and ordinary dementia a decrease of 1.1 and 1.6 per cent. respectively. Of the average annual number admitted into asylums during the five years 1890-1894 we find that 49.3 per cent. are reported as suffering from mania, 25.8 per cent. from melancholia (private female patients to total private admissions amounted to 34 per cent. however), 11.3 per cent. from dementia, 4.5 per cent. from senile dementia, 5.5 per cent. from congenital forms of mental disorder, and the rest (3.6 per cent., from other forms of insanity. Of these cases 70.3 per cent. are recorded as being first attacks, 8.4 per cent. were epileptics, 8.7 per cent. general paralytics, and 25.6 per cent. suicidal cases (females to males in the proportion of 26 to 22).

The causation-table (XXIV.) requires comparison with the tables of previous years to determine whether any of the tabulated originating factors of mental disease show any progressive influence on occurring insanity. The tables in this report deal with the averages for the last five years, and

comparing these with the averages of the ten years preceding we find that alcoholism as a cause preponderates by 1·1 per cent. over the average percentage of the years 1879-1888, and that accidental injury and old age likewise show an increase by 1 and 1·5 per cent. respectively. Probably from a more careful investigation into the life histories of patients it is now found that 23·2 per cent. show hereditary influence against 20·9 in the decade 1879-1888, and that previous attacks account for 1·4 per cent. more of certified cases.

The causation table of general paralysis (XXVI.) as in previous years leaves us still a wide choice in determining the ætiology of this affection, and it must be somewhat disappointing to the believers in the syphilitic origin of this malady to be confronted with the returns from medical officers in asylums here given that to 2·9 per cent. only of general paralytics has venereal disease been attributed as the essential causative factor. This proportion differs so widely from that of continental asylums that some effort should we think be made to trace out more satisfactorily the antecedents of general paralytics with reference to syphilis. It would be of some assistance in clearing up this point could we obtain from the Commissioners a classification into pauper and private, male and female cases, as well as a summary of the professions and callings of general paralytics so as to discover in what ratio the disease occurs among females, especially of the lower social grade.

The number of voluntary boarders remaining in registered hospitals on January 1st, 1895, was 113, in metropolitan licensed houses 19, and in provincial licensed houses 42. Of the 204 admitted into registered hospitals during the year, 51, or nearly 25 per cent., had to be certified as patients. No fewer than 103 boarders were admitted into one hospital.

The remaining tables in the Report deal with the location and distribution of pauper insane, and comprise the annual returns from various institutions, etc. We may note some points of interest in the Commissioners' remarks on the various asylums, etc., under their supervision.

With the completion of the new asylum for Sunderland Borough, the total number of County and Borough Asylums now comes to 69. The admissions into these institutions during the year comprised 13,081 patients with "first attacks," 1,309 transfers, 55 recertifications, and 2,187 re-admissions. Post-mortem examinations were made in 4,760 cases (the number of deaths being 5,927), a percentage on

the total number of deaths of 80·3 and an improved percentage of 1·6 on the ratio last year. The Commissioners discuss at length the need there exists for the proper provision of special accommodation for pauper, idiot, and imbecile children, and they dwell once more, not without ample reason, however, on the lack of energy displayed by local authorities in providing separate means of treatment at a small cost for private patients of the poor middle class. An interesting feature of this year's Report is the short *résumé* of the history of each asylum in the kingdom which the Commissioners have drawn up mainly to exhibit the overcrowded state in which the majority at present continue. The list they give of public institutions thus over-populated is certainly a distressingly large one. The insanitary states of some asylums (the effect mainly of imperfect or defective drainage and contaminated water supply) call for remark, and we are certainly of opinion that so long as such enormous institutions remain unconnected with the supplies obtainable from large waterworks, so long will some of these defects continue; the initial outlay may have to be excessive, but the results will ultimately be far more satisfactory than at present. Reference to the Report will show that it is mainly in outlying asylums far removed from towns that these insanitary grievances persist.

The suicides in County and Borough Asylums during the year amounted to only ten, and the Commissioners very properly comment favourably on this extremely low percentage, when consideration is taken of the fact that 25·6 per cent. of cases under treatment are classified as being actively suicidal. Too much praise, we think, cannot be accorded to all, both superiors and subordinates, at this most satisfactory evidence of the constant and vigilant care which is being exercised over the insane in public institutions. Six of these suicides were by hanging (5 males and 1 female), three by strangulation (2 males and 1 female), and one, a female, by throwing herself under a train. The deaths by misadventure, other than suicide, numbered only 19, and of these there was but one due to suffocation during an epileptic fit, and this even was hardly the consequence of neglect or lack of vigilance. The other causes of accidental death were drowning (1), fractured thigh (1), fractured ribs (6), burns (1), impaction of food on the larynx (3), shock after gastrotomy (1), an accident on a railway line (1), ruptured intestine (1), ruptured bladder (1), accidental suffocation (1), and accidental poisoning (1).

The cost of maintenance in County and Borough Asylums per week per head is given as follows :—

			s.	d.
In County Asylums	...	...	8	11½
In Borough Asylums	...	...	9	6½
In both taken together	...	...	9	1

and a comparison of the various items of expenditure with that ten years ago shows that there has been a diminution of 6½d. per head in County Asylums, and 11¾d. per head in Borough Asylums per week in the cost of provision, while there is a satisfactory compensation for this diminution under the headings of “necessaries, etc.” The total amounts show an increase of 1¾d. in County, and a diminution of 5¼d. in Borough Asylums.

We intentionally refrain from commenting on the remarks made by the Commissioners with reference to Registered Hospitals; we would refer the curious to the Report itself. We need hardly note that but one suicide (of a male, a voluntary boarder who threw himself under a passing train), and three deaths from other causes (one of a lady accidentally poisoned by eating yew leaves, one of a gentleman who died from exhaustion following mechanical restraint, and one of a female idiot child from scalding) have been recorded.

The licensed houses in the kingdom now number 76 (25 metropolitan and 51 provincial), five licenses having been relinquished during the year. There was but one suicide (a male, by strangulation) in metropolitan licensed houses, but three suicides (all males, by hanging, shooting, and precipitation), and one death from fractured ribs have been recorded in provincial licensed houses. The number of patients resident in all licensed houses on January 1st, 1895, shows an increase of 325 on the number on the same date in the previous year, private patients having diminished by 17, and resident paupers increased by 342. The Commissioners, we may note, do not always record all the changes in licenses, or all the structural improvements effected in licensed houses; we are aware of some that have never been specified, though happening during the last few years.

The number of single patients shows no increase—there were remaining under care on January 1st, 1895, 428, and on January 1st, 1890, 446, an actual diminution of 18 since the new Act. Of the total number remaining, 143 were chancery patients.

On the whole the Report maintains its high standard as an

official record of the careful supervision exercised over the certified insane, and save for some misleading statistics, to which we have drawn attention, should prove a valuable aid to all who have at heart the welfare of the mentally afflicted.

Thirty-Seventh Annual Report of the General Board of Commissioners in Lunacy for Scotland. Edinburgh. 1895.

The Report opens with a reference to the retirement of Sir Arthur Mitchell from the Board of Lunacy, with which he was associated from its institution in 1858, and a fitting tribute to the large part he has taken in the development of the system of lunacy administration as it now exists in Scotland, in particular that part of it which forms its distinguishing feature, the care of the insane in private dwellings.

The number of lunatics under official cognisance in Scotland on 1st January, 1895, was 13,852. This represents a total increase during the year 1894 of 552, an addition of 10 per 100,000 of population as compared with 3 in the preceding year. This increase in proportion to population is distributed as follows:—Private patients in establishments have increased by 1; pauper patients in establishments by 7; and in private dwellings by 2.

The table on page 152 shows the distribution of all lunatics on 1st January, 1895.

During the year the following changes have taken place as regards the registered insane. Private patients have increased by 87 in Royal and District Asylums, and by 5 in private dwellings, and decreased by 6 in private asylums; pauper patients increased by 222 in Royal and District Asylums, by 112 in parochial asylums, by 7 in lunatic wards of poorhouses, and by 112 in private dwellings. The total increase of 539 registered insane is the highest recorded annual increase in 20 years, and is made up of 87 private and 452 pauper patients; the increased number in establishments is 422 and in private dwellings 117, the former being made up of 82 private and 340 pauper patients. The increase in establishments is considerably above the average annual increase of the quinquenniad 1891-95, the corresponding figures for which are 49 and 206 respectively.

This addition to the number of pauper lunatics is the largest that has taken place in any one year since the

Number of Lunatics on 1st January, 1895.

Mode of Distribution.	Male.	Female.	Total.	Private.			Pauper.		
				M.	F.	T.	M.	F.	T.
In Royal and District Asylums ...	3857	4100	7957	851	880	1731	3006	3220	6226
„ Private Asylums...	64	88	152	64	88	152	...	...	...
„ Parochial Asylums, <i>i.e.</i> , Lunatic Wards of Poorhouses with un- restricted Licenses ...	815	911	1726	...	...	...	815	911	1726
„ Lunatic Wards of Poorhouses with restricted Licenses ...	420	444	864	...	...	...	420	444	864
„ Private Dwellings ...	1110	1680	2790	37	76	113	1073	1604	2677
„ Lunatic Department of General Prison ...	6266	7223	13489	952	1044	1996	5314	6179	11493
„ Training Schools ...	38	16	54	...	...	...	...	...	...
„ Training Schools ...	200	109	309	88	54	142	112	55	167
Totals ...	6504	7348	13852	1040	1098	2138	5426	6234	11660

institution of the Board of Lunacy in 1858, and, commenting on this fact, the Commissioners point out that the increase is markedly greater in some localities than in others. Thus, dividing the country into three separate districts, it is found that in those counties which have large urban centres, Aberdeen, Edinburgh, Forfar, Lanark, and Renfrew, the increase per 100,000 of population amounts to 10, while in those which have smaller industrial centres, either towns or rural mining districts, Ayr, Dumbarton, Linlithgow, Selkirk, and Stirling, it is 13; and in the third group, comprising the purely Highland counties of Argyll, Inverness, and Ross, it amounts to no less than 33. In the first two groups the population is increasing, and the increase of pauper lunatics is therefore partly attributable to increase of population, but in the case of the Highland counties the population is diminishing, and the explanation of the increasing pauper lunacy must be sought elsewhere. It is, in the opinion of the Commissioners, to be found in a gradual change of public view which manifests itself in an increasing disposition to acquiesce in, or even urge, the removal to asylums of persons who formerly would not have been regarded as fit subjects for asylum treatment. That the granting of State aid for the maintenance of pauper lunatics has done much to encourage this change of public sentiment, especially in the poorer districts, is a view which is strongly upheld by the Commissioners. "In counties," they say, "in which the rental is low in proportion to area and population, the burden of the maintenance of the insane is acutely felt, and when a large part of that burden is removed by a contribution from the State, the objections of the ratepayers to the removal of insane persons to asylums as pauper lunatics is much lessened, and the poorer counties have thus been enabled to do what the richer counties would more or less have done without State aid." Removal to an asylum necessarily means pauperism to the insane among the great mass of the people, whether they come from wealthy or from poor localities; but the poorer localities show a special phase of the influence of State contributions which is not observable in wealthy localities, or at least not at all in the same extent. In the poorer districts there is shown an increasing readiness on the part of persons having insane or imbecile relatives residing at home, and not requiring asylum care, to claim assistance on their account. Thus in the three Highland counties above-named the number of persons intimated as pauper lunatics

and left under care in private dwellings was 44, while in the case of the five counties referred to as having large urban centres the number so reported and left under private care in a population nearly ten times as large was only 42. The great body of the people in the Highlands show a growing tendency to look to the State for help in every difficulty. They now more fully recognise the fact that the aid they seek in cases of lunacy is given to some extent from the funds which are not parochial, and they often have erroneous ideas as to the extent of this aid and as to their "right" to share in it. This may give rise to an evil, if it has not already done so; but, as a matter of fact, when the question involved is one of removing a patient to an asylum, the cost to the ratepayer is still sufficiently great to put a check upon the willingness of the local authorities to accept the burden unnecessarily, and there is no evidence that the encouragement which local authorities derive from State contributions, in sending to asylums persons who require such treatment, has as yet gone beyond what is desirable in the interests of that class of the insane poor.

Of the admissions to establishments 515 were private patients, which is 16 less than during the preceding year and 19 less than the average for the five years 1890-94, and 2 661 were pauper patients, 148 more than during the preceding year, and 233 more than the average for the quinquenniad 1890-94.

The number of patients discharged recovered from establishments is 27 below that of the preceding year, and 13 below the average for the five years 1890-94, while the number of pauper patients recovered, though 55 below the number for the preceding year, is 58 above the average for the quinquenniad 1890-94. The following table shows the recovery rate per cent. of admissions for a series of years.

Classes of Establishments.	Recoveries per cent. of Admissions.					
	1885 to 1889.	1890.	1891.	1892.	1893.	1894.
In Royal and District Asylums ...	39	38	35	41	42	37
„ Private Asylums	34	35	28	44	38	50
„ Parochial Asylums	42	46	42	43	44	40
„ Lunatic Wards of Poorhouses ...	6	11	13	4	5	6

The death-rate for all classes of establishments, as the following tables show, is considerably under what it has been for several years.

Classes of Patients.	Proportion of Deaths per cent. on Number Resident in all Establishments.					
	1885-89.	1890.	1891.	1892.	1893.	1894.
Private Patients	6·6	8·4	9·0	7·0	8·1	5·8
Pauper Patients	8·1	8·1	9·6	9·0	8·6	8·2
Both Classes	7·7	8·2	9·5	8·7	8·5	7·8

Classes of Establishments.	Proportion of Deaths per cent. on Number Resident.					
	1885-89.	1890.	1891.	1892.	1893.	1894.
Royal and District Asylums	7·8	8·5	9·5	9·0	8·8	8·1
Private Asylums	8·0	7·8	5·1	7·5	5·7	5·2
Parochial Asylums	8·9	8·9	12·7	8·4	9·8	8·5
Lunatic Wards of Poorhouses	5·5	4·0	4·4	6·1	4·5	4·1

Table X. of Appendix A shows that general paralysis as a cause of death continues to increase among males, but is somewhat less among women. The average percentage for the 36 years ending 1893 is for males 19, and for the 37 years ending 1894 it has risen to 19·2, while for women the corresponding figures are 4·8 and 4·7

With regard to pauper lunatics in private dwellings, the proportion so accommodated has during the year undergone very little change. The additions during the year represent an increase per 10,000 of population of seven to those accommodated in establishments as compared with two disposed of in private dwellings. The percentage of all pauper lunatics who were in private dwellings on 14th May, 1894, was 23·3, which is an increase of 0·1 as compared with the preceding year, and is about the average for the last five years. This tends to confirm the previously expressed opinion that this proportion would seem to represent the limit of this method of disposal. Dr. Fraser, who has been promoted to the full Commissionership, makes some remarks on this subject which, embodying as they do an experience of 17 years, are well

worth quoting. He expresses, emphatically, the opinion that "the mode of care by which a large number of the insane are placed in private dwellings under adequate control and local supervision, as is the case in Scotland, is one which both secures in the best manner the welfare of the patients, and lessens the burden of their maintenance on the public rates." He quite admits the necessity, in order to prevent abuses, neglect and improper treatment, of careful and systematic supervision, but unhesitatingly affirms that this method "has in Scotland, as regards a certain selected class of the insane, produced results superior to what could be attained for those patients by any other mode of care." And, though his remarks contain no reference to the possibility of deleterious results so far as the public is concerned, this aspect of the subject is referred to by Dr. Lawson, who expresses the opinion that this mode of disposing of insane persons "causes no appreciable interference with either the performance of the duties or the enjoyment of the privileges of the general public." A short section is devoted to the Quinquennial Retrospect ending with 1894. The most prominent feature of this is the great increase, in proportion to population, of persons placed on the register of lunatics during each year, an increase, compared with the preceding quinquenniad, amounting to no less than seven per 10,000, and which consists chiefly of pauper lunatics. Removals from the register, excluding deaths, show no appreciable increase, and the deaths do not show much variation in rate.

The Development of Homo-sexuality. By MARC ANDRÉ RAFFA-LOVICH (authorised translation from the French Edition). Berlin : Fischer, 1895, 8vo., 39 pp.

The subject of sexual perversion has become distinctly fashionable of late years, and has grown to be one of those topics about which anybody having a large stock of expression in need of investment thinks he may sit down and write a book. Most of such volumes hardly deserve a more discriminating criticism than that with which Johnson received the maudlin utterances of Boswell, when his future biographer pressed upon the moralist the delightful amenity of the life of a bull in a rich pasture with plenty of heifers at his disposal, or some such thing: "Sir, this is sad stuff!"

An honourable distinction of the brochure before us

induces us to notice it at greater length than we otherwise would. Its author holds views of the validity of which we have not been able to convince ourselves as to the nature of the so-called "homo-sexuality." But in his suggestions as to dealing with the condition he shows a return to common sense, which give us hope that rational modes of thought on the subject are beginning to set in at last.

The terminology of venereal aberration is very defective in spite of all that has been written on the topic. Perhaps the phrase "perverted sexual feeling" is allowable, though, if a foreigner may indulge in such a criticism, it is surprising that the great German did not term it "sexual trieb" rather than "empfindung." But homo-sexuality is a bad word; etymologically it is a bastard, and it appears to us to be open to a worse objection—that of being self-contradictory. The essential meaning of sexual is contradicted by the prefix. The condition of sex is duality, dissimilarity and heterogeneity. Aberrations of the venereal appetite are, strictly speaking, non-sexual. In strict physiology it would be as logical to discuss drunkenness as an affection of the appetite of thirst, or opium eating as an affection of the appetite of hunger, as it is to regard pederasty as a sexual passion. In all three cases the end which the appetite, whether it be hunger, thirst, or sexual desire, subserves, is objectively obvious, and is fitting. It is true that to the reason of the subject the ultimate aim does not appear to be the impelling cause of his conduct. The satisfaction of a desire appears to him to be the cause, instead of the maintenance of the individual, or the continuance of the species, but this ought not to misguide the objective observer, nor make him, with reference to venereal affairs, dub that sexual which is truly non-sexual or contra-sexual. In fact, this seems to be one of the fallacies on which the doctrine of congenital sexual perversion is founded; that because desire for the opposite sex is normal, therefore desire towards one's own sex may exist and be, *quâ* the individual, normal too. But that there should be such a passion, so unfitting to the wants of the organism, so "contrary to the constitution of the nature" (to use old-world phraseology), is a thing harder to believe than any miracle we have ever heard of, a thing the evidence in support of which must be of the most irresistible and overwhelming kind in order to produce conviction. To many it will appear that such irrefragable evidence is not yet forthcoming.

On this point, however, Raffalovich does not seem to think that there can be any question. He speaks of homosexuality as a very frequent condition, a condition, indeed, which has always existed, but which is becoming more frequent; a condition which it behoves society to look to. We cannot see that he brings forward much fresh evidence, but, considering the nature of most of the evidence which has been adduced by his predecessors, we cannot blame him for that. Of the untrustworthiness of much of this stuff our author is well aware. "The histories and confessions of perverts are in this respect little reliable. I have already said, and say it again, the homo-sexual are liars, and when they speak of their childhood they try to whitewash themselves, or to make themselves interesting through passion or vulgarity." Again, "It is a mistake to believe that sexual perverts recognise each other. This is one of their fraudulent statements which is often repeated." And again the author tells us that Krafft-Ebing "accepts somewhat too readily the lies of the most lying of all people." "Krafft-Ebing appears to me to give too much credence to the assurances of his patients. The homo-sexual are naturally very pleased to have a man of his reputation and merit to fight their battle for them, and one readily understands that his kind heart which beats warmly for humanity has more than once carried him away."

Although giving his adherence to the doctrine of congenital sexual perversion, and although holding that we have little power to cure affections of the sexual feelings, our author has an irrepressible hopefulness which is as healthy as it is rare in these latter days.

In the first place he will not subscribe to the modern tenet that because one has passions which one has inherited, be they normal or abnormal, one has no choice but to yield to them. He notes, somewhat paradoxically he admits, that there is no absolute line of demarcation between the hetero-sexual and the homo-sexual. He is inclined in practice to look at both very much in the same way. The perverted, he says, who sigh and whine, and take writers into their confidence, are creatures who would have sighed and whined even if they had been hetero-sexual. It is not very easy to find a person of the opposite sex who will prove thoroughly and equally satisfactory to the sexual feelings to the intellect, to the social and family instincts. Why should the sexual perverts expect that

[ideal happiness] which the hetero-sexual [normal] man so seldom attains to? "How many hetero-sexual are unhappy in their sexual life?" "Whether he is perverted or hetero-sexual, the individual is always to be pitied who is deficient in chastity, moderation, moral force, intelligence, spirit and piety." It is, he tells us, an error to suppose that the homo-sexual must necessarily give all their attention to their relations with their own sex. Such a state is not invariable even among the normal. "There are," he tells us with an odd touch of humour, "very many among the hetero-sexual who, when they are in good health, do not give all their thought incessantly to women."

Raffalovich does not think much good is to be done in this condition by hypnotism, and he suggests that it is hardly right to encourage the unfortunate possessor of perverted instincts to marry and propagate a race of "urnings." We suspect that those who advocate this course hardly quite believe their own promises, for the doctrine of heredity is presupposed in that of congenital sexual perversion, and thus they advise the doing of a little evil that a very much bigger evil may come, surely a very indefensible proceeding.

A very different course is recommended by Raffalovich. "He who has a pervert to deal with, who also really wishes to improve, should strive to occupy him, to interest him, to show him other objects which he can attain with energy, rather than make a woman hunter of him who will afterwards be the miserable husband of an unhappy wife, and the father of children doomed to suffer as much as himself or more. If the virtue of chastity stood in a little better repute, I would recommend that to physicians as the real means to prepare the perverted for marriage and paternity. It is much more efficacious than the plan of sending a patient to a 'puella.'"

Putting aside the moral aspect of the case, we are inclined to think that he has sound sense on his side. Anyone who has given any thought to sexual physiology must know that there is no function so much disturbed by attention as the sexual one, a fact which is no doubt at the root of sexual hypochondria, to which condition again it is very likely that many cases of so-called sexual perversion may be attributed. However, in practice, everybody has had to treat cases of so-called "functional" impotence, and we know that it is a thoroughly unsound practice to recommend

fornication, and that such a recommendation has been occasionally followed by the most disastrous results.

Self-restraint, abstinence, and chastity, are according to Raffalovich, the modes of cure, and where cure is not to be effected, a continuance of self-restraint and celibacy are to be practised, and an earnest endeavour is to be made to find some other means of working off energy than an abnormal sexual one.

To the advanced thinkers of to-day these methods will seem horribly crude, perhaps "fetichistic," and surely Philistine, but yet we doubt whether, after all that has been written on the subject, any more excellent way has been suggested. Surely, however, they ought to commend themselves to those who believe that the "urning" possesses a female soul in a male body, inasmuch as they are precisely the methods which circumstances have forced upon an enormous number of the female sex in every civilised country.

L'Abstraction et son rôle dans l'éducation intellectuelle. Par FRÉDÉRIC QUEYRAT. Paris: Félix Alcan, Editeur. 1895.

This small book, addressed especially to those interested in the work of education, is the natural sequel to the author's "L'imagination et ses variétés chez l'enfant." After dealing with the psychology of abstraction, the differences of aptitude for abstraction exhibited by various minds, and the causes of such differences, Queyrat emphasises its importance in intellectual culture and devotes the concluding chapter of his book to the best means of cultivating the power of abstraction in children.

As the evolution of language, of writing, of sciences, etc., accompanies the progressive passage from the concrete to the abstract, we also find that the power of abstraction is greatest in the most cultured minds; at the bottom of the ladder we find animals devoid of this power, then savages unable often to count beyond four, and whose language is deficient in names to express abstract ideas, until gradually we arrive at a Pascal with a mind full of the power of mathematical abstraction.

The causes which explain the great diversity observed in individuals, or races, as regards their aptitude for abstraction, are *heredity*, which in relation to the species plays much

the same part that memory does with regard to the individual, and the *power of attention* (which includes as a concrete form power for work). Added to these is education, which may help or modify to a considerable extent the other two.

It requires but a superficial glance to appreciate the great part played by abstraction in intellectual culture. Without abstraction thought would not exist. The uncultured individual has an indolent intellect; he is the puppet of his imagination; he is deprived of that lucidity and repose which an exact knowledge of things gives to the mind. Abstraction assists the memory and renders it less fugitive, and it affords the mind a powerful means of avoiding numerous errors. Mindful of the far-reaching influence of this faculty, M. Queyrat justly dwells upon the means of developing the capacity for abstraction in children, which far from being repugnant to them is a real source of pleasure. Even from the early age of ten the child may be taught to trace the underlying general ideas among the concrete ideas which he has already acquired. In the study of proverbs, grammar, fables, history, etc., his mind may be readily trained to deduce the idea from the image, the law from the fact.

This is an interesting and careful essay well worthy of careful perusal.

Meralgia Paræsthetica. Von Dr. WLADIMIR K. ROTH. Williams and Norgate. London: 1895, pp. 24. Price 9d.

Dr. Roth, Professor of Medicine at Moscow, wishes to introduce a newly-discovered disease, which he calls meralgia, a pain in the outside of the thigh. It begins with a feeling of numbness or coldness which soon passes into burning pain. Standing or walking aggravates the distress so that the use of the limb sometimes becomes intolerable. Sitting down or half reclining causes it to disappear, but on stretching the body quite out it returns. It is clearly a neuralgia of the nervous cutaneous femoris externus. Sometimes the pain extends a little further than the ordinary course of the nerve, which Dr. Roth accounts for by quoting the observations of Sappey that the external cutaneous femoris sometimes spreads to the knee joints, and sometimes joins in with the crural nerve. Pressure on the trunk of the nerve does not aggravate the pain. Dr. Roth has seen fourteen cases of

this affection. Only two of these patients were women, in five cases there was pain on both sides. The causes assigned are intoxication through alcohol or lead, or the sequelæ of typhoid fever. The affection sometimes lasts for years without getting much worse. The treatment employed was blistering in the course of the nerve, massage and use of galvanism. The author gives short reports of the whole fourteen cases. Neuralgias or neurites of single nerves are not uncommon; but Dr. Roth has not found this special affection often described. He refers to the paper of Dr. M. Bernhardt in the "*Neurologisches Centralblatt*," Nov. 6th, 1895, which describes several cases of the same affection. One patient was a military surgeon who got leave to give up wearing a sword as it hurt the place which was painful. He also mentions a colonel who when on duty wore a scabbard without the sword for the same reason. All Dr. Bernhardt's cases were on one side. He found the affection lasting long, but not dangerous to life. The treatment employed was brine baths, massage and electricity.

Mentally Deficient Children: Their Treatment and Training.

By G. E. SHUTTLEWORTH, B.A., M.D., etc. London: H. K. Lewis, 1895, pp. 134. Price 4s.

In this volume Dr. Shuttleworth endeavours to give such descriptions of the diagnosis, prognosis and treatment as may help a medical man when consulted about a mentally feeble or deficient child. By mentally feeble he means idiotic or imbecile. Dr. Shuttleworth commences by a historical retrospect in which he gives credit to Dr. Edward Seguin as the leader in the movement towards the education of idiots. This he fairly deserves. In the sagacity which brought him to the right plan of education, in his skill in applying methods of teaching to the feeble capacities of idiotic children, in his kindness, patience and devotion, Dr. Seguin had no rival; but Dr. Shuttleworth's honest admiration does not allow him to see anything amiss in the work of the master, who, like most enthusiasts, brought the one colour of his mind in which to see everything. He quotes with apparent approval Seguin's definition of idiocy as "an infirmity of the nervous system, which has for its effect the abstraction of the whole or part of the organs and the faculties of the child from the normal action of the will," but no one knows better than Dr. Shuttleworth that the primary infirmity of idiocy is in the brain centres, and

consists in the want of intelligence, not in the want of will power.

Dr. Seguin's summary of the success of his methods scarcely answers to the reality. He says, for example, that "from 25 to 30 per cent. of idiots have come nearer and nearer the standard of manhood till some of them will defy the scrutiny of good judges when compared with ordinary young men and women." Exaggerated claims of success, often advanced through adjectives capable of great latitude of meaning, may be useful for the time being, but there are certain disadvantages in too glowing promises of what can be done for idiots. Parents of the weak-minded, who take such promises in good faith, are apt to become disappointed when they find their children are not rapidly changed into normal beings, and sometimes blame the teacher for not performing impossibilities, instead of being grateful for results which have severely taxed his time and care. However, it may be said that training will do a great deal towards the improvement of idiots and imbeciles, though it will never remove the radical deficiency under which they labour. We are convinced that idiots and imbeciles must be the object of lifelong care. The practice of the charitable institutions admitting idiotic children of the poorer classes by the votes of subscribers, to give them a training of five or seven years and then return them to the parents, who have grown unaccustomed to the burden of caring for them, has more worldly craft about it than real charity.

As Dr. Shuttleworth himself observes, "It is not indeed to be expected that without some form of tutelage even the trained imbecile can hold his own in the outside world, and in the majority of cases it may be appropriately said —

"'Tis not enough to help the feeble up,

But to support him after.'

There is no doubt, however, that such support is rendered infinitely easier by methodical training, and the burden to the friends much lighter."

The chapter on the diagnosis of mental abnormalities shows the profound knowledge of the author. The only critical observation we can make is that the medical practitioner new to the subject would be apt to be led away by the crowd of morphological defects and varieties of type which Dr. Shuttleworth takes from the large stores of his knowledge. A picture with fewer touches and more stress laid upon the functional deficiencies of the idiotic child would probably prove an easier guide. After some sagacious re-

marks on the hygiene and medical treatment, Dr. Shuttleworth passes to educational training, which thus occupies nearly half the book. As the author observes, such training requires to be conducted by the physician and teacher going hand-in-hand, for idiocy is at once a disease, often complicated, and an incapacity, mental and nervous. Dr. Shuttleworth gives an account of the laborious investigations which he made in conjunction with Dr. F. Warner and others into the number and condition of the children in the London Board Schools who labour under nervous affections which render them less capable of learning than other pupils.

This book may be regarded as the sum of many previous contributions to the literature of the subject which have made Dr. Shuttleworth's name well known to the medical profession. The author shows throughout a conscientious desire to give due credit to fellow-workers in the same field. His remarks upon the moral and religious training of imbeciles show much judgment and consideration. The book is illustrated with plates of lithographs and woodcuts in the text which are well chosen and well executed. Altogether Dr. Shuttleworth's book may be recommended as giving a clear and connected account of our present knowledge of idiocy and imbecility, especially in its practical bearings.

Philosophy of Mind; an Essay in the Metaphysics of Psychology.

By GEORGE TRUMBULL LADD. New York and London: Longmans, Green, and Co., 1895, pp. xiv. and 414. Price 16s.

In this book Professor Ladd has dealt with the philosophical problems which suggested themselves to him when treating of the subject of empirical psychology. A work of this description demands serious attention. Apart from the intrinsic interest of the subject itself, the author's long-continued researches into the facts and laws of scientific psychology render it particularly valuable to those who desire to obtain an open-minded and just estimate of the relations existing between empirical psychology and philosophy.

The author has made an earnest attempt to bring various speculative opinions face to face with the conclusions of the science of mind, and in so doing he presents to us a treatise which—in the more special meaning of the term—may properly be called metaphysical. The subjects selected for treatment are by no means exhaustive, but in the main

they are those of the greatest interest to the student of mental phenomena, and it is from the empirical standpoint that they are considered.

Throughout the work grave fault is found with those writers upon the scientific aspects of psychology who fail to keep consistently to the purely scientific point of view. The author, however, acknowledges that a certain form of metaphysics is the natural and necessary accompaniment of every scientific study of mental phenomena. "The study of psychology as a natural science is not really the pursuit of a knowledge of correlations between phenomena wholly *without any metaphysics whatever*. It is rather the pursuit of this science, with only *such metaphysics* as is naively assumed in all scientific inquiry. Psychology may then, for the time being—if one is willing to leave it so—be called 'a natural science,' but only as it is founded upon a natural, uncritical, and unreflecting metaphysics."

The metaphysical assumptions and implications which are woven into the philosophy of nature and the physical sciences are, and we think rightly, held as possessing no claims of superiority over those involved in the philosophy of mind or the metaphysics of psychology. Were we to strip the physical sciences of all metaphysical assumptions, how little of these sciences would be left! Their conservation would appear to depend more upon the structures the scientists have built as metaphysicians than upon what they know as mere scientists. Professor Ladd has legitimately dealt with the metaphysical questions involved in certain scientifically-established facts and laws of mind, and his speculations have no foundation other than in experience.

After dealing with Hoffding, James, and Flournoy as inconsistent rejectors of metaphysics, he concludes that the only legitimate choice left for the psychologist is between an uncritical dualism and the adoption of such a definite metaphysical point of view as Volkmann's and Wundt's.

The arguments as to the nature of the "concept of mind" are sometimes difficult to follow. The main point he desires to establish would appear to be that all consciousness, and every phenomena of consciousness, makes the demand to be considered as a form of functioning, and not as mere differentiation of content. "Every state of consciousness is not only capable of being regarded on the side of passive content of consciousness—it must also be regarded on the side of active discriminating consciousness." "Consciousness regarded as objectively discriminated, and con-

sciousness regarded as discriminating activity, are only two sides, as it were, of one and the same consciousness." The element of self-activity in all self-consciousness is laid great stress upon.

The alienist will find much of interest in the chapter on Consciousness of Identity and so-called Double Consciousness. The latter phenomenon is treated in an interesting and suggestive manner. In the main we agree that many of the current physiological and psychological theories are not only inadequate, but also misleading. The desire to observe and emphasise the rarer and more abnormal extremes of the reported cases of "double consciousness" has undoubtedly led to the neglect of many other phenomena which fitly serve to bridge the apparently impassable gulf between them and the most ordinary experiences. Even the most strikingly abnormal cases of double consciousness, when *all* the phenomena connected with them are carefully examined and duly estimated, seem likely to show that it is possible to interpolate an innumerable series of gradations so as to shade up to our ordinary experiences. Possibly in the future we may be able to fill up many of the gaps, and find that every contingency fits in with the possibility of the occurrences being within the realms of diffuse consciousness, or as reflex phenomena, without the direct concentration of attention or of self-consciousness.

The theory of the unity of mind is advocated strenuously. The reality of mind is supported on the assumption that knowledge implicates reality. Professor Ladd believes that the only and indubitable reality which belongs to mind is its being for itself, by actual functioning of self-consciousness, of recognitive memory, and of thought.

In the chapters which deal with the relations of Mind and Body the author challenges the principle of psycho-physical parallelism. He believes that even the simplest relations between the phenomena of the lowest order of consciousness and the concomitant cerebral processes are far too fluctuating, complicated, and changeable to be subsumed under this principle. "Of parallelism in time there is only an incomplete and broken analogy, and when one tries to think out clearly the conception of a complete qualitative parallelism, one finds the principle soon ending in inadequacy, and finally becoming unintelligible or absurd." That the proof of the parallelism is as yet inadequate and incomplete we assent; but our failure to demonstrate the complete quantitative and qualitative details of the two series of phenomena does not

furnish us with a direct negation of any parallelism whatsoever. The inadequacy probably exists in our own defective conception of the actual nature of the relations existing between mind and matter. In any case, our partial knowledge of that relationship does not warrant a direct negation of the possibilities and probabilities, nor does it form a satisfactory ground for any positive assumption as to psychological monism. Professor Ladd's acceptance of the latter doctrine appears to be based in great part upon the inability to imagine even a moderate dualism, which we hold to be susceptible of further definition and elaboration. The wiser course would appear to be to accept a moderate dualism until we know more about the body and the mind, and not to entirely negative possibilities by theories which cannot be verified.

The remaining discussions on the "Origin and Permanence of Mind" and the "Place of Man's Mind in Nature" are of considerable interest as bearing upon ethical and religious questions.

We may say of this book that it is written in the author's best style. The destructive criticism is in places markedly effective, and the book ought to be widely read as one of the most able and suggestive contributions of recent years to the literature of the philosophy of mind.

Thoughts on Religion. By the late GEORGE JOHN ROMANES, M.A., LL.D., F.R.S. Edited by Charles Gore, M.A., Canon of Westminster (Fifth Edition). Longmans, Green & Co. London: 1895, pp. 184. Price 4s. 6d.

This is a story of transition from a carefully reasoned scepticism anent religious things, and a life of conscientious abstinence from prayer, to "(1) 'pure agnosticism' in the region of the scientific 'reason,' coupled with (2) a vivid recognition of the spiritual necessity of faith and of the legitimacy and value of its intuitions; (3) a perception of the positive strength of the historical and spiritual evidences of Christianity." But "pure agnosticism," as understood by Dr. Romanes, in his later years, is a phrase which should be explained to the general reader. It is, in fact, the agnosticism of Darwin and Huxley, as to whatever may lie beyond our sense-perceptions, and must not be confounded with the doctrine of the unknowable, the implied impossibility of revelation, the form of agnosticism attributed to Herbert

Spencer. It is by virtue of this particular meaning only that the phrase clearly marks the first stage in the interesting conversion of belief. The distinction is one which should be thoroughly grasped at the outset by all readers of the "thoughts," otherwise the true bearing of the author's later views will be somewhat difficult to apprehend.

In 1873, we are told by Canon Gore in the admirable and lucid preface which he has written to these papers, an essay of George Romanes gained the Burney Prize at Cambridge, the subject being "Christian Prayer considered in relation to the belief that the Almighty governs the world by general laws." At this time the essayist was only 25 years of age, but few philosophical conclusions are so confirmed at the age of 25 as to remain stable through life. Before 1878 Romanes had published, under the pseudonym of "Physicus," a "candid examination of theism," in which he repudiated the theistic hypothesis proffered in his academical essay. In the last chapter of this anonymous work the writer summarised his arguments into the conclusion that the hypothesis of "Mind in Nature" is superfluous to account for the phenomena of Nature; and as the latter writings of Romanes consist very largely of a criticism of this position, and of his own presentation of it, we think Canon Gore has done well to reproduce the entire chapter in the preface. As possibly furnishing some forecast of what was likely to follow, it is worthy of observation that Romanes does not at this period appear to have been particularly happy in his conclusions in favour of the "persistence of force" and the "indestructibility of matter," supplanting belief in the existence and virtue of a sustaining mind. "It is with the utmost sorrow," he says, "that I find myself compelled to accept the conclusions here worked out; and nothing would have induced me to publish them save the strength of my conviction that it is the duty of every member of society to give his fellows the benefit of his labours for whatever they may be worth. . . . And so far as the ruination of individual happiness is concerned, no one can have a more lively perception than myself of the possibly disastrous tendency of my work!" And again: "I am not ashamed to confess that with virtual negation of God the universe to me has lost its soul of loveliness." . . . From all of which it becomes clearly evident that whatever the transition of intellectual belief may have been in Dr. Romanes' case, the *transition of will*, a different matter altogether, and often without doubt a stupendously important one, was not of a very wide character

—a fact which is, of course, capable of more than one interpretation.

Some time before 1889 Romanes wrote three articles, which, for reasons unknown, did not appear in the "Nineteenth Century." The first two of these are now given to us in the present volume. They contain a critical examination of his own previous publications, and although sceptical in their main conclusions, they afford some indications of a return to, at least, theism. The illustrations employed, and especially the one of a marine bay, as affording, on the one hand, apparent evidences of design, or, on the other, the effects of previous operations of Nature, without the intrusion of any independent external influence, are admirable, and a passing presentation of the pessimistic philosophy for examination also strikes one as being in the author's best style. These papers are succeeded by a collection of notes for a work on a candid examination of religion, which, as we are told by Canon Gore, form the chief *raison d'être* of the volume before us. Here we find traces of a careful study of the "Christian evidences," evidently designed by Romanes during the last few years of his life as preparation for the production of that larger work which unfortunately he did not live to complete. The "thoughts" are of a fragmentary character; "pure agnosticism" is apparently the leading idea, Christian agnosticism the ideal, as yet but imperfectly realised. They touch on causality, faith, dogma, the position of woman in Christianity and Christian demonology, thus including a wide field of observation.

There can be little question, however, that it is in regard to natural, rather than revealed religion, that this work will be found to possess its greatest value. Whereas, in the controversial arena of natural religion there is ample room for the scientist to bring the results of his researches into action, and to utilise his own particular modes of investigation, the examination of the fundamental dogma of the incarnation and the historical evidences of Christianity would seem to require a special training and a procedure of a different, or even an exclusive order. This fact must be stated notwithstanding that it is in the former sphere that the force of Romanes' scepticism lies. While Canon Gore is anxious that Christianity should profit by the return of a clear thinker and attractive writer to the orthodox faith, there will be others who, whatever their creed or no creed, search for observations and arguments based upon the ultimate possibilities of teleology in Nature. These will do well to

possess themselves of this little volume; in fact, no one who wishes to be thoroughly abreast with modern controversy can afford to do without mastering its contents. And so admirably have these posthumous papers been arranged by that subtle controversialist and master of style, Canon Gore, that nothing weak has been allowed to find a place. If the "notes" appear a little inconsequential at times the fault is simply the failure of a considerable purpose which remained unfulfilled.

It remains to ask what may be the true meaning of this important episode in the distinguished career of a well-known and highly appreciated man of science. And the reply must be that the conversion, or reconversion of the late Dr. Romanes to Christianity does not, judging from the intellectual point of view and from the evidences before us, figure forth as a ratiocinative conquest of the orthodoxy of the age. There can be little doubt that his return to the "Communion of the Church of Jesus Christ" (*sic*) was rather a fulfilment of the unrecognised influences of his own inmost personality and soul experience than a yielding to the force of argument or persuasion. We cannot discern such points of contact between his earlier and his later meditations within the realm of pure reason as would enable us to conclude that he had successfully solved even the least among those particular problems which at one time appeared to him to be essential, and to offer no insuperable difficulties of solution. But the fact of his return is deeply interesting. It would perhaps have been more interesting still had it been possible to add more about the man himself and his later life. We must, however, rest satisfied with Canon Gore's decision, and certainly nothing more beautiful, nothing more entirely appropriate, could have been chosen than the well-known quotation from St. Augustine with which he brings a work which contains not the faintest suspicion of any literary flaw, to an eminently touching close.

Mind and Motion and Monism. By the late GEORGE JOHN ROMANES, M.A., LL.D., F.R.S. (Crown 8vo., pp. 170). Messrs. Longmans, Green and Co., London. 1895.

This small volume is mainly a reprint of certain of the author's published essays. To readers who are acquainted with the metaphysical or controversial problems of the

ultimate natures and relations of mind and matter this book will prove somewhat disappointing. The section dealing with mind and motion does not set forth a just estimate of the value of the data afforded in the respective departments of physiology and psychology. The author has given much attention to the general refutation of materialism, and more especially with regard to the mechanical aspect of volition. He nevertheless pays an extreme tribute to physiology in the statement that "every particular change of mind has an exact and invariable counterpart in some particular change of body," and this he regards as a fact which is established to the satisfaction of every physiologist. This invariable and exact physiological counterpart of mind he regards as quantitative. Considering that the behaviour of a single nerve under electrical stimulation has not yet been accurately determined, the alleged quantitative and qualitative parallelism or proportionality between physiological and psychical events can scarcely be admitted as an established principle by all. At present we are unable even to state cerebral activities in terms of motion; hence it seems to us that any definite acceptance of the principle of psycho-physical parallelism (beyond the probable parallelism in time) is premature, and, as yet, not capable of verification. From a destructive point of view the author has no doubt dealt severely with materialism, but the hypotheses advanced in the cause of monism seem to us far from being satisfactory. The subjects are discussed, nevertheless, in a suggestive and interesting way, and the book is well worth reading.

Dualism and Monism and other Essays. By the late Professor VEITCH, with an introduction by R. M. WENLEY, M.A., D.Sc. Wm. Blackwood and Sons. 1895, pp. 221.

This small volume contains some of the more important of the unpublished papers of the late Professor Veitch, and in bringing them together Mr. Wenley has ably accomplished a very difficult task.

The introductory chapter is an interesting and broad-minded criticism of the Professor's position in philosophy. He is described as having been a pure scholar and thinker, singularly devoid of craving, either for fame or for any of the more solid rewards that sometimes fall to the lot of men of high intellectual attainments. A Scot, by ancestry, by

training, and in his public career, he was to a large extent national in his cast of thought. Largely influenced by Hamilton, he followed the time-honoured inductive method of the Scottish school—self-observation and reflection.

From the outset till the last the Professor's very mind was critical. He sympathised with the intuitional standpoint, but contented himself mainly with passing effective criticisms on what he considered to be mistaken theory. He was quick to detect and expose with unsparing scorn the logical errors which arose on the enunciation of the theory of physical evolution and its consequent materialism. That he was justified in checking the tendencies to adopt extreme positions is manifest to all, and his critical attitude, although somewhat irritating to constructive philosophers, in the end contributed to advance.

The chapters dealing with Dualism and Monism and the history of Philosophy are reproductions of what are considered to be some of the best examples of Professor Veitch's constructive writings, and although many may disagree with the main assumptions involved, all will confess that the present volume is one of great interest, and Mr. Wenley is to be congratulated upon the masterly manner in which he has achieved his task.

Semi-centennial. Proceedings of the American Medico-Psychological Association at the Fiftieth Annual Meeting, held in Philadelphia, May 15-18, 1894. Published by the Association. Printed at the Utica State Hospital.

We must commence our review of this volume by tendering to our American colleagues our hearty though somewhat belated congratulations on having attained a definite point whence they can look back with satisfaction on the birth, infancy, and adolescence of their Association, and look forward with confidence to an indefinite span of virility. Our own emotions have been stirred by a similar event so recently as to make our congratulations the more earnest. A great success attended the meeting, if the number and quality of the papers offered is taken as a criterion. The bulk of the report, over 300 pages of large octavo, must perforce lead to our review being more general than particular. We sincerely grieve that the death of Dr. Hack Tuke has placed in other hands a task that would have been most congenial to him.

As might be expected, a considerable portion of the matter is retrospective. The President, Dr. Curwen, presents a masterly sketch of the personal story of the Association. The life-history as well as the work-history of the "original thirteen," and of the more prominent after-members, is most interesting. The reader obtains thereby an idea of the trials, the disappointments, the energy, the determination that have been incident to the development of the vast system of asylum work, which, notwithstanding all cavilling, forms a landmark in the history of humanity. The fact that Dr. Curwen was present at the initial meeting, and was acquainted with all whose lives he so admirably delineates, makes his address peculiarly trustworthy and valuable. He in common with other contributors declaims with justifiable warmth against the pernicious system of taking into account a Superintendent's political views not only in appointment to, but retention of his office. The address concludes with much wise advice which can well be accepted by all from the lips of a Nestor.

Dr. Cowles takes the therapeutical line for his review of the past half century. Though he founds his story on the records of the Maclean Asylum, he is quite catholic, and connotes the progress of treatment in Europe. The practice of depletion, its subsequent discredit and replacement by "supporting treatment" and symptomatic medication, the development of rest treatment, of the theory and practice of elimination, etc., are all graphically traced.

Dr. Godding, without precisely binding himself to the past half century, and in very general terms, describes the evolution of the present hospital for the insane. At the close he said, "I sometimes ask myself if the energy expended on these buildings has any counterpart elsewhere? For superintendents as a rule have very little worldly goods to show for their work here. Piles of bricks and mortar, some dry statistics, an overworked heart and brain, a dependent family, and the reputation of being nearly as cranky as his patients, make up the sum of his life's history."

Dr. Alder Blumer selects the literature of psychiatry as his line of retrospect, while Dr. Fisher treats of New England alienists of the last half century, and Dr. Hurd of alienists in general during the same period. All these serve to fill in in detail a picture of striking proportions, the evidence of hard consistent labour, of increasing mastery

and skill, and brought the nearer to truth by its lights and shades.

But there never was a picture which did not invite criticism. So here. To Dr. Weir Mitchell was confided the task of exhibiting what is underneath, or what he considers to be underneath, these pleasant tones. To him was, apparently against his own wish, given the opportunity of delivering the annual address. He explains at the outset that he gave to those who asked him to speak full warning that though he would have liked, as befitting a birthday, to have addressed the Association pleasantly, a stern sense of duty impelled him to speak otherwise. Notwithstanding this warning he was invited to proceed, and those who perhaps would have borne with complacency the whips of wise Solomon were treated to the scorpions of a Rehoboam. Without doubt Dr. Mitchell launched a scathing indictment against everything connected with American asylums, Boards of Supervision, Boards of Management, medical officers and nurses, an indictment which, if justified to the full extent, would have falsified everything else said at this great meeting, and which in our judgment is itself in great measure falsified by the evidence of good work contained in this report. Of course there is a considerable substratum of truth running through the address, for unfortunately lunacy administration offers a peculiarly apt field for demonstrating the inferiority of one's neighbours. We have on this side of the Atlantic passed through similar but milder tribulation not long ago—not so long ago that we have forgotten the arguments used against asylum science, but long enough ago to have afforded ample opportunity for the rendering of judgment by those whose judgment was invoked. Possibly Dr. Mitchell felt justified in discovery of "torpor" in American asylums. Certainly if he was in that belief he was entitled to administer some stimulating treatment—even such a shower bath as follows.

"But it is the arraignment of the neurologist which ought incessantly to trouble you and the Boards which you have to manage—for the management of managers is an important business. It is this outspoken discontent which ought to make you ask how far you yourselves are responsible. If we are right, neither States, nor Boards, nor you are living up to the highest standard of intelligent duty.

"Frankly speaking, we do not believe that you are so

working these hospitals as to keep treatment or scientific product on the front line of medical advance.

"You hold to and teach certain opinions which we have long learned to lose. One is the superstition (almost it is that) to the effect that an asylum is in itself curative. You hear the regret in every report that patients are not sent soon enough, as if you had ways of curing which we have not. . . They are placed in asylums because of the widespread belief you have so long, and as we think, so unreasonably fostered, to the effect that there is some mysterious therapeutic influence to be found behind your walls and locked doors."*

"As to work for the chronic and convalescent insane, I never yet saw in America the hospital where all was done that can be done in this direction."

This sort of thing, of which there is a sufficiency, may do some good, but can do little harm. But is there any necessity, or indeed any justification, even in possible extremities, for the hissing cautery?

"This lack of medical confidence is of recent growth. Once we spoke of asylums with respect; it is not so now." The denial of the respect of others, if established, must inevitably lead to loss of respect to oneself, and how without self-respect can Dr. Mitchell expect from his hearers that good and reforming work for which he calls so loudly? We will go back to Dr. Curwen's address, and cull therefrom an extract which should suggest something of use to Dr. Mitchell, "The trials, the temptations, and the labour of men in every sphere of life are sufficient to depress and cause to despond many who are striving honestly and heartily to discharge the duties incumbent on them in the sphere in which they are called to act, and it behoves every man to cheer and encourage them and assist them in every reasonable effort they may make."

In strict conformity with precedent Dr. Mitchell concludes his address with an ideal sketch of "a large perfected hospital for the possibly curable insane," and oddly enough he says "It should of need include a home for the

* "A certain minimum number of fellow-patients is needful to establish that system of method and discipline which forms a great part of the curative influence of asylum treatment. The great importance of this influence upon the insane mind we have always insisted on. Orderly conduct and obedience to conventional rule, though it be but that of an asylum, is the first step towards reasonable processes of thought and healthy states of emotion," etc., etc.—*Bucknill and Tuke*.

education and uplifting of the chronic and hopelessly insane." Sisyphus rolled his stone painfully to the top of the hill, only to find it roll down again against his will. Shall we roll our "hospital" idea up to accomplishment, and then deliberately slide it down back into the slough of the composite asylum?

All the attributes and arrangements (bar one) of this imaginary institution are excellent, and are quite capable of attainment, for indeed they exist already, perhaps not as a whole, but only where they can be profitably used.

We are afraid that if Dr. Mitchell wishes every acute and curable case to obtain the complete advantages and amenities of the institution, he will likewise have to sketch out and procure a new pattern of patient. The exception taken above is to his proposal as follows: "My patient is not at once put in charge of a nurse. An assistant, male or female, a physician is with him for three days or more (one of his own class or above it). He shall study the case, and quietly record its mental peculiarities," etc., etc.

For a fuller study of the mordant—we had almost said truculent—spirit of the address we must refer the reader to the text itself. Dr. Mitchell avowedly criticises as a "neurologist," and claims that he speaks the views of other neurologists whom he has consulted, and he pointedly compares asylum scientific work with that done in the three last decades by "the little group of neurologists here." We protest that neurologists in all their pride are not the best judges of work which cannot be tabulated and displayed like their own.

"Cosmic Consciousness," by Dr. Bucke, is the sole purely psycho logical contribution. He claims that this element, the exact nature of which is a little difficult to grasp, has the following evolution—Vitality, Excitability, Sensation, Consciousness, Self-consciousness, Cosmic Consciousness. It is not an exaggeration or proliferation of the immediately preceding rung in the psychological ladder; on the contrary, it is of a different nature and superimposed. It has made but little headway in humanity, Dr. Bucke having only discovered twenty-three cases, the first one going back to Buddha himself. Then come St. Paul, Mahomet, Dante, Boehme and Walt Whitman. From the study of these he lays down the following essentials—instantaneous development, an immediate consciousness of a bright light, possibly an overweighting voice, to be followed by "a consciousness

of the life and order of the universe—an indescribable moral elevation—an intense and exalted joyfulness and a sense of immortality—annihilation of the sense of sin, and an intellectual competency not simply surpassing the old, but on a new and higher plane.” Dr. Bucke predicts that as man’s receptivity increases so will he take on this condition more frequently and earlier. This is somewhat alarming in view of its apparently constant relation to eclampsia. We fear that if and when his prediction comes true, it will be time for the sane to build themselves asylums—using the latter term in its old-time sense.

The relations of crime to insanity furnish some interesting papers. Dr. Allison, of Matteawan, gives some results of his experience at that State Hospital. His views, though strong, are moderate. He will not admit that “there is any physical condition of which it can be predicated that every subject thereof is of necessity and without choice a criminal.” On the other hand, “Setting aside the inferior types of humanity exhibited in institutions for the care of imbeciles and idiots, there is probably no other special class of mankind wherein mental, moral, and physical degeneracy is more pronounced . . . than among the convicted inmates of our various penal institutions who suffer from the different forms of mental disease.” “Taken as a whole the criminal class exhibits defects both of morals and of intellect, and to an equal degree its members in early youth show evidences of incomplete physical development.” Of the 3,700 male convicts in the New York *prisons*, 41 per cent. were under 25 years of age at the time of conviction.

The types of insanity vary from those of ordinary institutions. Acute mania and noisy demonstrations or exhibitions of motor excitement are not common—the quiet forms, sub-acute or chronic, are mostly found.

Convicts when on becoming insane they are sent to the asylum, are mostly lazy, prodigal in their ideas of living, etc. They are inclined to believe themselves to be wronged, and their insanity generally develops along these lines. They become secretive and suspicious, and cherish fixed beliefs that they are oppressed, that their mates are hostile and conspiring against them, that their food is poisoned, and that they are to receive bodily harm, and to be put to death.

These delusions provoke them to attacks on others, but seldom lead to maniacal outbreaks. Such cases retain their

reasoning faculties to a large extent, and are apt to make premeditated assaults to protect themselves. In many cases these people fraternise and become proportionately more dangerous. Among "life" prisoners insanity is exceedingly prevalent, more so than can be accounted for by remorse, the hopelessness for the future, and monotony of prison life. The fact suggests to Dr. Allison a doubt whether in many cases the mental condition has been thoroughly investigated at the time of trial. Seventeen per cent. of all "life" convicts in New York are in Matteawan. This proportion would be largely increased but for the fact that several cases of terminal dementia were pardoned and transferred to county institutions. As a class, these "life" patients are superior to the ordinary insane convict. Dr. Allison has found that out of 1,200 convicted cases admitted into Matteawan, 65 per cent. had *both parents* of foreign birth. In the discussion following, Dr. Brush subvents these startling figures. The New York State census of 1890 showed that almost exactly one-half of the insane were of foreign birth, and of the remaining half nearly one-fourth were of foreign parentage.

Dr. Allison is of the opinion that the people at large do not recognise the influence of insanity on crime. The people want a definite sentence of months or years. "The old idea of retributive justice prevails—an eye for an eye, a tooth for a tooth. The populace is, and always has been, anxious for blood."

Two cases involving questions of medico-legal procedure were presented. The first was that of a man, H. T. Schneider, who killed two men. Drs. Chapin, Godding, and Brush read papers thereon under the heading of "A New departure in medical jurisprudence." The facts were these—Schneider was put on his trial and was found guilty. He appealed to the Supreme Court on a plea that the murders were committed in self-defence. Insanity was not then pleaded. The appeal was disallowed, and matters proceeded almost to hanging point. The warden and the doctor of the gaol then became of the opinion that he was insane. The Court refused to take any cognisance of such opinion till Dr. Godding was called in. He certified that there was *primâ facie* evidence of insanity. Then the Court took a novel step—novel as far as Columbia was concerned. It appointed a Commission of Drs. Chapin, Hamilton, and Dana to assist it in coming to a decision whether insanity

existed then, holding that if the culprit was insane he should not be hung. It is to be particularly noted that the existence of insanity in bar of execution, and not of insanity at either the time of the murder or of pleading, was the point in question. The Commission by special order of Court examined the prisoner together and separately, and examined on oath all others whose evidence they desired. The Court allowed the prisoner to call three medical and many other witnesses, who were cross-examined in open Court by the Commission. Counsel for the prisoner wished to cross-examine the Commission both verbally and by written questions. The Court refused to allow this. The Commission after a few days reported their opinion that the prisoner was sane, and on this the Court refused to stay execution longer, and Schneider was hung, all appeal to the Supreme Court of the United States and even to the President being fruitless.

In the discussion that followed most speakers deprecated the allowing Schneider to summon his own medical experts, on the reasonable grounds that if they confirmed the views of the Commission they were redundant, and if they differed they detracted from the weight and authority of those impartial alienists who were in the first place appointed by the Court for its enlightenment. Dr. C. K. Mills, however, with Judges Mason and Mills, who took part in the discussion, thought that cross-examination of the Commission should have been allowed.

The question that naturally arises in our minds is whether such a procedure as detailed above has any advantage over our own, by which the fact of a convicted murderer being sane enough to be hung, is settled by the Home Secretary on such advice as he may desire to obtain.

One advantage certainly is that the terrible responsibility of forfeiting or sparing human life is shifted on to shoulders which have often to bear such responsibility. A disadvantage, however, is that the more formal arrival at a conclusion is not so conducive to the exercise of mercy as would be a private study of all circumstances, whether they come or do not come within the set limits of legal procedure.

The second case was presented by Dr. Dewey, and was that of Prendergast, who shot the Mayor of Chicago, Mr. Carter Harrison. Here the plea of insanity was raised on trial, but defeated, and as no other defence could be offered in face of the admission of the facts by the prisoner, he was

condemned. Then his attorneys ingeniously appealed for stay of execution on the same ground as was chosen in the preceding case, viz., insanity at the time the punishment was due. The stay was granted, and he was put on his trial again. Two points of difference from Schneider's case here occurred. First, he was tried by a jury, and not by a Court of Judges; and secondly, he was found sane (and subsequently executed), notwithstanding that twelve physicians, ten of whom had special experience, declared their opinion that he was insane. We think that there can be no question that review by a Home Secretary is by far preferable to a retrial by a jury.

Schneider's case presents no point of interest beyond the procedure; his insanity, or alleged insanity, being confined to a statement of belief that attempts were being made to poison him, of which belief Dr. Godding saw no evidence beyond the statement. But Prendergast was undoubtedly one of those unfortunate men who make medico-legal history. A blow on the head as an infant, a dull and backward boyhood, peculiar and solitude-seeking puberty, were followed by adolescence, in which he was threatened with consumption. However, he got stronger, and took an interest in law, the profession of which was above his social status. He took copious doses of "Henry George" and other socialistic literature. He became argumentative to wearisomeness, quarrelsome, and after a time disappeared from his home, conducting a religious mission, or thinking that he was so doing. On his return he bothered his former Catholic teachers, who all thought him insane. He wrote postal cards to the Pope and others with advice. He advised the Secretary of the Treasury on the finances of the country. Soon after the election of his victim as Mayor of Chicago he told his mother that his influence had secured the election, and that he was to be made Corporation Counsel. He called on the then incumbent of the office, who thoughtlessly told him that he should have the office, and introduced him to some subordinates as the "new boss." Prendergast's wish for the office was connected with his desire to conduct the burning agitation which was going on about the elevation of the railroads in the City of Chicago. There was much complaint about these being in the streets, whereby hundreds of lives were annually sacrificed; and by the prominence which, as an official reformer of these evils, he would gain, Prendergast aimed at satisfying his vanity and political ambition. His

hope was doomed to disappointment, and labouring under this he called on the Mayor and shot him. His examination by Dr. Dewey and subsequent measurement by Dr. Talbot revealed a cranial formation which would seem to be in support of the arguments of the criminologists. Mentally he showed himself to be self-satisfied and egotistical, full of self-importance and cynical consciousness of superiority. His supreme confidence in his ability and authority was in strange variance from his ignorance, logical weakness, and puerility.

Dr. Dewey thus sums up the case:—"The form of mental disease existing is plainly a primary developmental insanity, the condition of degeneracy quite generally described under the term 'paranoia.' There is imbecility of mind, and there are delusions."

Dr. Babcock traced, in a paper well fortified with statistics, the general history of tuberculosis in asylums, and comes to the following conclusions on certain points, which we have selected out of several:—

Tuberculosis is two or three times as common in institutions for the insane as in the general population.

Among the insane two-thirds of the cases have had an asylum residence of over one year.

The disease is frequently the result of hospitalism, and its prevalence may be considered to be a test of the sanitary condition.

In private houses the insane are not more liable to phthisis than other people.

History, clinical and bacteriological investigation prove the disease communicable, and being communicable, is preventable.

There is probably much truth in the contention that some amount of phthisis may be prevented by strict disinfection, and that, given proper hygiene, the rate among patients may be largely reduced, but we cannot quite accept the statement that the insane are not more liable than the sane.

Dr. Babcock lays down some excellent rules for disinfection and prophylaxis.

Dr. Flick, of Philadelphia, supported the necessity for treating the disease as an infectious one, instancing the kingdom of Naples, where a severely penal system of notification, etc., has practically eradicated the disease.

Drs. Joscelyn and Moulton independently preach the "gospel of fat" with no uncertain voice. Their points are

made convincingly and strikingly, some of the increases in weight accompanying recovery being portentous, 63 pounds on admission rising to 125 on discharge, 86 to 132, 17 pounds put on in 17 days, 13 pounds in 13 days, and so on. Most of these cases lost a little weight as their mental health became thoroughly re-established after discharge.

It occurs to us that this is a fact that might suggest a possible danger—can we over-feed a case? Is there not a time in the course of every case when it is necessary for the mind to stir itself after a certain amount of compensatory rest? May we not delay that time too long by inducing a comfortable, after-dinner, don't-bother-me contentment? A certain amount of caution is required even in this most desirable line of treatment.

The discussion following evolved from Dr. Pearcey the remarkable statement that his policy in cases of starvation is to let them severely alone—very seldom indeed to force them to take food. He contends that to tube a patient tends to fix an otherwise possibly transient delusion. His patients go one, two, or, in extreme cases, three weeks without food, and, in bed, keep up extraordinarily well. We cannot help wondering what these patients' brains are doing all this time.

"Confusional Insanity," by Dr. Worcester, is, as he says, an attempt to somewhat revise present classifications of insanity, but though he quotes authority from Drs. Spitzka and H. C. Wood, we cannot endorse his endeavour. Being dissatisfied with such simple divisions as mania and melancholia because some acute cases do not fall naturally under either of these heads, and because others show at varying times symptoms of first one and then the other, he prefers to fall back on the symptoms and course of disease as the most satisfactory principle of classification. Apparently he treats confusion not only as a symptom, but really as a condition on which other symptoms depend—symptoms such as vague inconsistent delusions, incoherence of thought, absurd actions, inconstant emotions, undressing, throwing things out of the window, a lethargic or stuporous state, cataleptic rigidity, motor excitement, tendency to violence, noise and loquacity, apprehensiveness, etc. If Dr. Worcester is right, then mania and melancholia, and indeed dementia, must hide their diminished heads. It is obviously putting the cart before the horse to take a symptom and tack on to it all conditions in which the symptom is found, and we

think that Dr. Worcester is wise in not attempting to do this. He takes the more logical, and indeed necessary course of somewhat arbitrarily defining what cases are to come under the heading, but we feel sure that no success will attend his attempt to carve a new variety out of old-established favourites.

General paralysis forms the groundwork for papers by Dr. Phelps, who deals with its varieties and analogues; by Dr. Hepburn, who gives some excellent cases showing the early eye-symptoms; and by Dr. Hoyt, who discusses the tropho-neuroses.

Dr. Kellogg has a very smart and crisp paper on the "Frequent disorder of pneumogastric functions in insanity." He goes over *seriatim* the distribution of the vagus nerve, offering suggestions as to the way in which certain clinical phenomena may be explained by a consideration of the normal and abnormal exercise of function in its various branches.

Before closing this sketch we must take note of certain statistical matters brought up by a Committee appointed to inquire into—(1) The duration of life in the insane; (2) the permanency of recoveries from various forms of mental disease; (3) length of interval of mental health between attacks of mental disease in patients discharged recovered.

The report of the Committee laments the increasing magnitude of the task as it is taken more and more in hand, and the absence of universally accepted data from which to start. In view of these they requested permission to delay their report, and in the meantime brought up tables devised for the purpose of collecting information in suitable form. They, in common with all predecessors, have been driven to the necessity of laying down "assumptions, which, if accepted, will permit some degree of progress in the direction of uniformity." But can these assumptions be universally accepted? We take no notice of the inquiries as to the duration of life. For studying the other questions two confessedly arbitrary assumptions are taken; first, that recurrent cases must be got rid of by limiting to two the number of accountable recoveries in an individual; second, that only those suffering from acute mania, acute melancholia, and their various sub-divisions, and lastly acute alcoholism, shall be classed as curable. Why not acute primary dementia under whatever name that perfectly distinct disease may go? Then, also, a patient either recovers or he does not. His

recovery is no less a recovery because it is a third or fourth; and undoubtedly it should be taken into account in illustrating either the permanence or duration of relief from mental disease.

In truth, the question which dominates all such considerations is—what is recovery? This is a very shifting quantity indeed. There is another almost as important a question—how can the total of existing insanity be reached in order to obtain a really valuable calculation? If only the inmates of asylums are to form the basis there will be no insuperable difficulty in arriving at a conclusion, but unless the insane *not* in institutions are brought into account a very imperfect view can be taken on the points in question. Then if, for the sake of completeness, inquiry is made outside, there looms up the greatest difficulty of all—where shall the line be drawn between sanity and insanity? We much fear that the elaborate and carefully-prepared tables offered will not yield results commensurate with the labour involved in filling them up.

It remains to say that the volume is thoroughly well worth perusal. Touches of quaint humour here and there, quaint expressions, much good and in some parts really fine writing, relieve the serious tone which is inseparable from dealings with mental disease. The work is issued from the Utica State Hospital Press, and we trust that Dr. Alder Bloomer will eventually receive pardon for the mortal sin (*pace* Dr. Weir Mitchell) of being, as Medical Superintendent of that institution, in a sense responsible for the proper performance of work so alien to his own.

Myxœdema and the Thyroid Gland. By JOHN D. GIMLETTE, M.R.C.S., L.R.C.P. London: J. and A. Churchill, 1895, pp. 121. Price 5s.

Dr. Gimlette has succeeded in producing an interesting account of myxœdema and the thyroid gland in this small volume.

The book is divided into three parts. Parts I. and III. deal with myxœdema; Part II. deals with topics relative to the thyroid gland. Each division is concise and lucid. Myxœdema emerges from obscurity, passes through the stages of recognition and experimental treatment, and we

are finally left with the impression that there is at least one disease of which the physician, without undue presumption, can say, "This is curable."

The author, while admitting the obscure ætiology of myxœdema, discusses the probable influences of age, sex, heredity, climatic influences, etc., pointing out the various views entertained by other observers.

In discussing the "symptomatology," Dr. Gimlette lays special stress on the three marked characteristics of the disease: progressive and gradual change in the skin; grave complication of the nervous system; and an affection of the intellectual faculties bordering on insanity. With regard to the latter, Dr. Gimlette states that "the mental symptoms form an important characteristic of myxœdema." In the succeeding chapter, however, he says that "true insanity ought to be considered as a complication." These two statements appear to us diametrically opposed. Every patient suffering from myxœdema is not insane, but the mental symptoms of all myxœdemic patients border on insanity. In patients with an insane heredity this mental condition passes into actual insanity, and the myxœdema certainly appears to be the direct cause of the mental disorder, so much so that when the exciting cause is removed (when the myxœdema is alleviated by treatment with thyroid extract) the insanity likewise disappears.

The differential diagnosis between myxœdema and closely-allied diseases is clearly stated in Part I., Chapter V.

Part II. deals with the thyroid gland. The anatomy is given in detail, and possible abnormalities noted. This is followed by a short account of development, supplemented by a few words on comparative anatomy. The author quotes certain investigations which prove that, in the lower vertebrata, the thyroid is a secretory organ acting in connection with the respiratory functions.

Part II., Chapter III., deals with the physiology of the thyroid, and Dr. Gimlette has therein recorded the many and diverse views held by various investigators at home and abroad, *e.g.*:—(1) It elaborates some substance especially necessary for the central nervous system; (2) it communicates to the hæmoglobin the faculty of fixing oxygen; (3) it is directly a blood-forming organ; (4) it is indirectly a blood-forming organ; (5) it plays a special part in the metabolism of the sexual organs; (6) it modifies or destroys substances which, circulating in the blood, are prejudicial to the general

economy ; (7) it secretes some substance useful to the general economy.

Dr. Gimlette states that the most important of all is "that it (the thyroid) secretes some substance useful, if not necessary, to the general economy." This appeals to us as being a most delicate way of closing a chapter in which the author trod the ground of bitter controversy, and it certainly cannot hurt the feelings of any of the many physiologists who each hold that his theory of the thyroid gland and its functions is the only correct one.

The pathology and treatment of myxœdema are brought up to date in the two chapters of Part III.

Dr. Gimlette's book is well worth perusal, being easily read and assimilated. We acknowledge with gratitude the labour he has bestowed on literary research, and the manner in which he has rendered his results easy of access.

The Pathology of Mind. By H. MAUDSLEY, M.D. (Second Edition.) London : Macmillan, 1895, pp. xi and 576.

In this new edition, which is a complete revision, Dr. Maudsley presents us with a book which must be regarded as the latest and best work of a school of writers which arose as a consequence of the enunciation of the theory of evolution. An extensive experience of mental disease, a fluent and incisive style, with graphic powers of delineation, together with a thorough mastery of scientific modes of thought, and a knowledge of literature too rarely discovered in the works of specialists, all these are evident throughout. If, in this volume, the trend of thought is distinctively ambitious, the statements made bear the impress of careful consideration, and the facts adduced are marshalled at the bidding of a master. It is the work of a powerful intellect at its best, modified and recast to "present the last ripe fruits of observations and reflections, the first green fruits of which appeared so long ago." It is, in fact, an English classic—long ago received as such by those interested in the phenomena of mental disease, and by those to whom clear thinking and correct expression are valuable. In his grouping of symptoms, his descriptions of traits of character, and his discreet use of an admirably simple diction, Dr. Maudsley is not surpassed by any writer on mental disease.

It is only when we attempt to plumb the depths of human

experience that we begin to doubt and to question Dr. Maudsley. On almost every page it is evident that he lays claim to adjudicate, in so far as the experiences of his subjects may be fairly contrasted with others, in so far as they may be weighed in the philosophic balance and estimated from a sociological and scientific point of view; evidently, we say, the author does lay claim to have proved to the lowest discoverable foundation the facts of mental pathology, and to have estimated their most recondite associations. Each reader will, no doubt, form his own opinion of the result; but we have reluctantly to abide by the conclusion that, notwithstanding his acute powers of observation, Dr. Maudsley's philosophy is frequently unsound, his psychology prohibitive of truth, and his sociology repulsive and unsuited to average humanity.

It is difficult to choose a thoroughly characteristic passage without exhibiting a mode of examination which deals only with one side of the truth, and in consequence raises objections and exceptions. One reads, and wonders how much of Dr. Maudsley's vivid descriptions of mental states emerges from the subject and how much from the author himself. A vivid imagination often perverts the plain facts of experience, and assuredly plays havoc with the subtle indications of mental phenomena. No doubt, the personal equation is appreciable in every one, and just what gives value to Dr. Maudsley's portrayal of individual cases is a danger in his statement of general conclusions. Take for example the very paragraph with which the work opens: "By insanity of mind is meant such derangement of the leading functions of thought, feeling, and will, together or separately, as disable the person from thinking the thoughts, feeling the feelings, and doing the duties of the social body in, for, and by which he lives. Alienated from his normal sense and from his kind, he is in the social organisation that which a morbid growth is in the physiological organism: something which, being a law unto itself, in the body but not of it, is an alien there, a morbid kind, and ought in the interests of the whole either to be got rid out of it or sequestered and rendered harmless in it. However, it has come about, whether by fate or fault, he is now so self-regarding a self as to be incapable of right regard to the not-self; altruism has been swallowed up in a morbid egoism."

It is evident that it is with society that Dr. Maudsley's true sympathies lie, rather than with the unfortunate

individuals of whom he treats. But, moreover, the word *egoism* may be strained to bear a medico-scientific meaning: it is by no means a term of universal application to the phenomena of insanity. We must demur to the general application of such a word to all those who may be self-asserting or self-absorbed, or even anti-social. It seems to us that Dr. Maudsley regards his patients rather as the victims of a sociological principle of natural selection, doomed to suffer effacement in order that the fitter may survive, than as human beings who may still cherish sympathies and desire associations with their kind. Many may and do exercise a great salutary influence on those around them, and this often by virtue of those very experiences (unexplained by Dr. Maudsley) to which the subject owes his segregation or perhaps an opprobrium quite equivalent. Of this principle, indeed, as underlying the life of humanity, Dr. Maudsley shows himself very fully aware. "When we look at facts sincerely as they are, not satisfied to rest in a void of speculative idealism and insincerity, we perceive that in every department of life the superior person uses his superior powers to the inevitable detriment of the inferior person, even though he may afterwards dispense benevolently out of his superfluity to some of those who fall by the wayside" (p. 26). But he apparently has little sympathy with those who would seek to improve upon this condition of things. "Were men to carry the moral law of self-sacrifice into rigorous and extreme effect they would perish by the practice of their virtues. When they had succeeded in eradicating competition, in making an equal distribution of wealth, in prolonging the feeblest life to its utmost tether, in banishing strife and war from the earth, in bringing all people on it to so sheep-like a placidity of nature that they would no more hurt and destroy, and to such an ant-like uniformity of industrious well-doing that no one would work for himself, but every one for all, they would have robbed human nature of its springs of enterprise and reduced it to a stagnant state of decadence. A millennium of blessed bees or industrious ants!" (p. 27). The idea is familiar to the economist, but certainly not Dr. Maudsley's version of it to the impartial philosopher.

We have made these remarks on one aspect of Dr. Maudsley's conclusions, and few, we think, will deny that he has raised his structure upon a scientific, not a humanitarian foundation. As for the desirability, the propriety, the necessity of this dual groundwork each man must judge for

himself. But when Dr. Maudsley, in his masterly manner, dissects and explains the phenomena of mental disease, we even then decline to accept his whole teaching. For example, he says, "So when the mental qualities are stripped off in retrograde succession by disease the individual loses first his best social or moral qualities, after that his family qualities, and last of all his general human qualities. Going through the regressive degenerations of madness, he ceases first to be himself, then loses his social and family nature, and last of all has nothing human left but the form and name of his kind" (p. 42). This view certainly will not harmonise with the actual facts, for while in many cases the evil propensities reveal themselves in an exaggerated form, in others they require protection against a similarly unregulated revelation of their own virtues (that of generosity for example). The truth is that as in periods of excitement or trial so in mental disease (a rule which requires very careful application) there is a tendency for men and women to exhibit themselves in unrestrained expressions of desire, as they are. Confirmation of the true principle may be obtained by referring to Dr. Maudsley's very next page. "When he has been forced and fitted into a special mould of character by an adopted special training, begun soon in life and applied steadily throughout it, he is liable easily to lose his acquired, and to revert to his real, nature like a domesticated species of animal turned wild, if the special conditions of his manufacture are entirely removed. A man struggling against his nature is like the ancient Grecian fighting fruitlessly against the fate foredoomed to him by the oracle."

True, but the foundations of the "real nature" are above all moral foundations, and it is only when a fundamentally depraved nature fails that the result is what Dr. Maudsley here and elsewhere would seem to believe it to be. The two views cannot be reconciled; they are not offered as dealing with individual examples, but as illustrative of that common law which underlies all examples. It must be admitted that throughout most of the deeper generalisations of the work before us we appear to find lurking the same malevolent spirit of contradictions; the inevitable conclusion being that although Dr. Maudsley's knowledge of mental pathology is vast, his philosophy of human life is doubtful, and although his powers of penetrating observation are unrivalled, his judgment in the more universal spheres of thought within which much of his work claims to be

written, is not altogether trustworthy. And taking into account these considerations one cannot feel surprised that the author should conclude his work in that pessimistic strain which is the inevitable outcome of his philosophical and psychological principles, his words affording by their very candour a startling contrast to the dreams of other enthusiasts of the materialistic school.

"A physician who had spent his life in ministering to diseased minds might be excused if, asking himself at the end of it, whether he had spent his life well, he accused the fortune of an evil hour which threw him on that track of work. He could not well help feeling something of bitterness in the certitude that one-half the disease he had dealt with never could get well, and something of misgiving in the reflection whether he had done real service to his kind by restoring the other half to do reproductive work. Nor would the scientific interest of his studies compensate entirely for the practical uncertainties, since their revelation of the structure of human nature might inspire a doubt whether, notwithstanding impassioned aims, plans of progress, endless pageants of self-illusions, its capacity of degeneration did not equal, and might some day exceed, its capacity of development" (p. 563).

Those acquainted with Dr. Maudsley's works are well aware of his attitude towards religion, that wide sphere of human experience which is as universal as the race itself. He seems to find no soul of truth in the enthusiasm of the religious or the imagery of the mystic, and there is, in consequence of this want of sympathy, something lacking in his presentiment of conclusions relative to these matters. His rhetorical and precise statements on questions of a highly controversial nature seem to us unscientific and misleading, and there is nothing blameworthy in leaving loose ends when dealing with questions which admit of no dogmatic demonstration.

While Dr. Maudsley's writings command the respectful attention of all who are interested in mental science, we cannot accept them as full and unbiassed studies on the sociological and philosophical aspects of insanity. Notwithstanding their apparent value, the interest of the record, the subtlety of the theory, the power of the exposition, we feel that they are out of sympathy with the general tenor of recent research and philosophic thought.

PART III.—PSYCHOLOGICAL RETROSPECT.

Associated Delusions and Transformation of Delusions.

Dr. H. Dagonet ("Annales Médico-Psychologiques," No. 1, 1895) draws attention to those cases which exhibit simultaneously delusions of a contradictory nature and to the alternation of different kinds of delusions, *e.g.*, delusions of persecution with those of grandeur, etc.—cases which are usually classified as folie circulaire, melancholia with delusions of grandeur, megalomania with delusions of persecution, etc. A girl, for example, admitted under his care with "religious" melancholia of several months' duration, is seized with acute mania, with marked excitement lasting a year, and then recovers. Again: M. becomes affected with active melancholia, which lasts three years, and passes into a chronic condition, marked with delusions of self-importance and exuberant activity, etc. The explanation is generally obscure. Cases in which we find simultaneously delusions of well-being associated with ideas of depression, or hypochondriacal delusions with those of grandeur, etc., may belong to general paralysis, or alcoholism, or dementia. In the hypochondriacal form of general paralysis, for instance, one nearly always finds associated delusions of grandeur, of wealth, etc. (cases of D., G., J., G., etc.).

Megalomania may be associated with or alternate with stupor.

Interesting observations of certain cases of anxious melancholia with delusions of negation (patient thinks he is a great criminal, is the devil, has Satanic power, etc.) point to an intimate association between melancholia and ideas of grandeur. Delusions of grandeur are certainly not necessarily a stage in the evolution of chronic delusional insanity with ideas of persecution, as Magnan and others believe, although the association is frequent; they frequently appear in the *early* course of the disease.

Dr. Cramer, in "Allg. Zeitschrift für Psychiatrie," contrasts the diametrically opposite views of Magnan and Krafft-Ebing concerning cases of delusional insanity of sudden onset, with epileptoid prodromata, hallucinations, etc. (Westphal's "Acute Verrücktheit"), and their relation to mental degeneration. Krafft-Ebing classifies them among the pure psychoneuroses, while Magnan looks on them as characteristic of degeneration.

Christian, as a result of careful observations on cases of delusional insanity, concludes that the ideas of grandeur met with in the "insane persecuted" arise as complications and not by transformation of delusions. Dr. Dagonet confirms also Christian's conclusion that "insanity of persecution," with or without ideas of grandeur, is of all forms of mental disease the one which most rarely ends in dementia.

In searching for the *modus operandi* in the transformation of

delusions or their association, we must not forget the alteration which occurs in the general sensation and feelings of the patient; that is the possibility of the new association of ideas being dependent on the affective state of the patient.

The *prognosis* in these cases (excluding more or less acute cases of alcoholism) is often very grave, but one must consider the underlying mental condition as of paramount importance.

The real pathological interest in these cases lies in *their course* and the general symptoms. To attach great importance to a certain group of delusions, *e.g.*, those of persecution, as is generally done, and very little to the accompanying delusions of grandeur, is unreasonable.

The Importance of Inquiring into the Mental Condition of Criminals.

In June, 1894, Dr. H. Monod ("Annales Médico-Psychologiques," No. 2, 1895) requested the superintendents of public asylums in France to forward him the notes of cases (among their patients) in which a verdict of guilty had been pronounced in the law courts for a crime *unmistakably caused by their mental disease*, and committed at some time preceding their admission to the lunatic asylum. A collection of 271 cases, extending over five years, was thus made—cases in which a medico-legal inquiry would have prevented undeserved punishment and disgrace. For obvious reasons (only asylum superintendents were consulted; several gave no replies; only those criminals subsequently declared *pauper lunatics* were scheduled, etc.) this only expresses a percentage of the "convict lunatics" condemned in the five years (1886, 1887, 1888, 1889, 1890), and 700 would be a fair estimate of these *preventable convictions*, *i e.*, 140 per annum.

This is a serious evil, and a remedy should be found. Dr. Monod suggests that magistrates should possess knowledge sufficient to decide in suitable cases upon calling in a medical expert, or there should be in some way a strengthening of the bonds which unite medicine with the law. The question requires study. We note that among the 271 cases, 223 were men; 96 were between 30 and 40 years of age; 94 were condemned for theft. In their order of frequency we find that 65 were cases of dementia or mental enfeeblement, 58 general paralytics, 21 either epileptic or hysterical patients, etc.

Notes of some of the most interesting cases are given at the end of Dr. Monod's article. We cannot but fervently pray for reform when we read of a general paralytic being condemned to six months' imprisonment for injuring a tree.

The Part Played by Fixed Ideas in the Pathology of Hysterical Polyuria.

A. Souques ("Archives de Neurologie," No. 94) relates at length the notes of a case of polyuria, and shows that in most cases of nervous polyuria, *sine materia*, hysteria plays an important part, the im-

mediate factor being a fixed idea. A man, A. D., æt. 37 years, was admitted in the Salpêtrière on May 12th, 1894, under M. Brissaud. On the mother's side, a neurotic history. Patient had infantile paralysis when three years old; later on he drank freely. At age of 28 he suffered from acute rheumatism. The illness began in November, 1893, after a blow on the head; at about the same time he had hysterical crises. On examination when admitted, he was suffering from left hemianæsthesia, bilateral narrowing of the visual field (70° left, 80° right), marked thirst, and polyuria. Observations carried over one month showed that he passed on an average 16-19 litres of urine per diem. Urine: Sp. gr. 1002-1003; no alb.; no sugar. Complains of dry mouth. Other secretions (but the urinary) almost suppressed. Sleeplessness frequent. Patient is depressed, irritable, and anxious. On June 13th treatment by hypnotism was begun, and gradually less and less urine was passed. On July 4th the amount is only four litres. On September 2nd he left the hospital practically well.

Unquestionably the patient was hysterical, and the rapid cure by hypnotism confirms the hysterical nature of his polyuria. Without denying the existence of traumatic polyuria, the author believes with Potain and others that hysteria is frequently the connecting link between traumatism and polyuria. So also as regards alcoholic polyuria, alcohol may be only a determining factor, hysteria being at the root of the trouble. Bearing in mind the importance of hysteria, 22 cases of hysterical polyuria have been found in the Paris hospitals during the last two years.

A careful consideration of the history of these cases shows the constant presence of nocturnal incontinence in childhood or of alcoholic excess later. This frequency of micturition, according to the author, no doubt becomes the origin of a fixed idea—increased micturition—i.e., polyuria. It is psychologically that one must consider the genesis of hysterical polyuria, and the intermediary between the fixed idea and the urinary syndroma seems to be some functional disturbance of the vaso-motor system controlling the kidneys. In favour of this view is the fact that hypnotic suggestion may effect a cure. The pathology of true traumatic polyuria points to the existence of vaso-motor centres for the renal secretion in the bulb, so that we may suppose that in hysterical polyuria the fixed idea is the point of departure of a cortical reflex, which ends in the bulbar vaso-motor centres of the kidney and inhibits their action. In addition to traumatic polyuria, the author accepts the existence of hereditary polyuria observed in degenerate families as a distinct irreducible class.

Raynaud's Disease and Erythromelalgia of Hysterical Origin.

M. Leopold Lévi ("Archives de Neurologie," No. 95) relates the notes of cases which were under the care of Prof. Raymond, accompanied with hysterical manifestations (polyuria, e.g.) and readily hypnotisable. The author shows that these vaso-motor phenomena

(Raynaud's disease and erythromelalgia) have their origin in certain emotions which give rise to sub-conscious fixed ideas, and in the process of cure the latter are modified by hypnotic suggestion.

The first observation is that of a woman, aged 43, the disease affecting the hands, feet, forearms, etc., specially on the right side; it followed on a moral shock. The patient, who had also suffered from rheumatism, was undoubtedly hysterical (convulsions, polyuria, etc.). The author also analyses the observations of Burot, Armaingaud, etc., on this affection, especially as regards the rôle of hysteria and the influence of the emotions in its causation.

A second case is that of a woman, aged 37 years, hysterical, hypnotisable, in whom a painful emotion, arising in childhood, persists and gives rise gradually to a fixed idea. After the death of her mother she develops right hemiplegia, with hemianæsthesia, cured by hypnotism; then is attacked with rheumatic fever. After the death of her sister the phenomena of "erythromelalgia" appear, principally affecting the soles of the feet. The pains are so severe that for four months the patient scarcely slept. The disease is modified from day to day by hypnotism, and ultimately completely cured.

The general conclusions are:—

A. 1.—There is a form of Raynaud's disease which is purely hysterical. It may originate or reappear under the influence of a moral emotion or shock; may disappear or be improved by hypnotism, but there remains a vaso-motor system easily affected.

2.—Acute rheumatism is frequently found in the antecedents of patients, and may determine the localisation of hysterical manifestations.

3.—The onset is sudden, the origin emotional. The disease is psychical. There are present urinary symptoms (anuria, polyuria).

4.—Gangrene may possibly occur.

5.—Cases of Raynaud's disease in hysterical patients, or due to emotional troubles, are numerous. Occasionally the phenomena are present in other members of the family (case of two sisters, father, and daughter).

B. 6.—There is a form of erythromelalgia which is purely hysterical. It is related to a vivid emotion or a sub-conscious fixed idea.

We also find a history of acute rheumatism, urinary phenomena, the sudden onset, or the variation of phenomena related to the ideas or feelings of the patient.

It is cured by hypnotism, but leaves a vaso-motor system easily affected by various emotions.

C. 7.—The facts observed are important contributions to the study of diseases due to the emotions.

They are additions to the already long list of vaso-motor troubles in hysteria.

They do not constitute distinct diseases, but groups of symptoms, which may pass into one another, and in the present instance proceed from the same neurosis—hysteria.

D. 8.—To explain the syndroma of Raynaud and that of Weir Mitchell (erythromelalgia) related to hysteria, the central theory must be accepted (*i.e.*, a neurosis, with localization in cerebro-spinal centres).

Raynaud adduced in support of this view of the pathology of local asphyxia the phenomena observed in the optic papilla (constriction of the central artery). We would insist, in addition, on the urinary troubles and the concomitant cerebral troubles (deep sleep, congestion of the face, etc.) observed, and, on the other hand, draw attention to the existence of asphyxia of the extremities in melancholia, general paralysis, and especially in “*la folie circulaire*.”

9.—It is necessary, in order to treat the patients and to appreciate the etiology of the syndroma, to investigate the psychological history of the subjects.

Hypnotism enables us to determine the immediate cause of the affection and to effect a cure.

Alcoholism in Children.

Dr. Paul Moreau [de Tours] (“*Annales Médico-Psychologiques*,” No. 3, 1895) carefully discriminates between drunkenness, dipsomania and alcoholism, and deals especially with the last. The causes are above all, hereditary predisposition and the “observance of custom of country or family” (example it might be called), and such occasional or exciting causes as thirst, curiosity, etc., which act usually in predisposed subjects. Menstruation in young girls may excite dipsomania, the subjects being generally degenerates or predisposed. The common forms of alcoholism in children are the “massive” (coma), the furious, the lively; the sad or melancholic form seems very rare. Among the pathological manifestations are violence to property or person, not infrequently delirium tremens—and, of course, cirrhosis. Prognosis is usually bad. Treatment must be prophylactic. In the case of crimes committed under the influence of alcohol, it is important to be severe, and extenuating circumstances, so often considered in the case of adults, should not be admitted.

Hysterical Borborygmi.

Prof. A. Pitres (“*Le Progrès Médical*,” December 29th, 1894) draws attention to the presence of *rhythmical* borborygmi in hysteria synchronous with respiratory movements, and the rhythmical character of which has apparently escaped the observation of most authors who have referred to the presence of borborygmi in hysterical subjects. He describes two typical cases. The attacks or crises of borborygmi are regular, lasting two to four hours; the noises begin suddenly, are loud, synchronous with respiration; a rumbling is evident on palpating the epigastrium and left hypochondrium; they cease when the patient lies down; the patient usually feels some discomfort; the crises end also suddenly. Emotional disturbance often seems to determine the origin of the trouble, and the immediate cause is

frequently the taking of food. The duration of the disease is long—years often—and it is a source of much annoyance to the patients. Antidyspeptic and antispasmodic remedies are without avail, and treatment altogether is almost futile. As to the explanation, it is uncertain whether they arise in the stomach or colon, but no doubt they depend on the *spasmodic* contraction of the respiratory muscles, so that Pitres looks on rhythmical borborygmi as one of the numerous varieties of the large nosological group of hysterical spasms.

Syphilis and General Paralysis.

Prof. Alf. Fournier ("Gazette des Hôpitaux," No. 128, 1894) lays great stress on the importance of collaboration from various special quarters in solving the problem of the relation of syphilis to general paralysis; we require a "syndicate of associated special observations." It is wrong to ask the general question: "Is general paralysis a symptom, a result, a complication of syphilis or not?" We must find a solution to the four following questions:—

1. Is there, or is there not, as a possible result of syphilis, a clinical syndroma which deserves the name of "syphilitic pseudo-general paralysis?"

2. May true general paralysis in any way be considered a complication of, or be derived from, syphilis? If so, with what degree of frequency?

3. Is true general paralysis, produced as a consequence of syphilis, of syphilitic nature or simply of syphilitic origin?

4. Is true general paralysis, produced as a consequence of syphilis, different clinically, anatomically, or otherwise, from general paralysis of different origin?

1. All observers must have met with syphilitic patients presenting such symptoms of general paralysis as: Muscular tremors (especially of hands and tongue), hesitation of speech, inequality of pupils, psychical troubles (enfeebled mind, impaired memory, alternating attacks of depression and exaltation, etc.), sensory disturbances, with partial paralysis or hemiplegia, etc., in whom the diagnosis between cerebral syphilis and general paralysis is, perhaps, impossible until the autopsy proves the presence of lesions of cerebral syphilis and not those of general paralysis. So that he concludes here that: *a.* There is unmistakably a clinical manifestation of cerebral syphilis which assumes the physiognomy of general paralysis, and *β.* To this Prof. Fournier proposes the name of pseudo-general paralysis, as it recalls more or less the pathological physiognomy of general paralysis.

2. In solving this question, we must remember the great frequency of syphilitic antecedents in general paralysis. Twenty-seven modern statistics from various quarters estimate this proportion at between 51 and 92 per cent., so that we are irresistibly led to the conclusion that syphilis constitutes a powerful factor in the etiology of general paralysis. And from his own experience, Fournier is led to consider as absolutely certain the proposition that a number of

syphilitics become general paralytics. And here we may add : that it is usually women of a certain class who become paralytics ; that general paralysis is relatively rare in country districts, among ecclesiastics, quakers, etc. ; that syphilitic antecedents are relatively much more frequent in general paralysis than in other forms of insanity (65 per cent. compared with 10 per cent., for example, in Régis's statistics) ; the common association of general paralysis with locomotor ataxy ; and, finally, the powerful argument of youthful general paralysis—all considerations which are in favour of answering question two in the affirmative.

3. This offers many obscure points to unravel, and one cannot wonder at the various theories advanced to explain the relation ; *e.g.*, that syphilis prepares the soil ; that syphilis only produces general paralysis in a prepared soil ; that general paralysis is a kind of residuum, a degeneration consecutive to former syphilitic lesions of the nervous system ; that general paralysis is the result of an infectious cachexia ; and, finally, the famous theory of syphilitic toxins, developed especially by Strümpell. Fournier's conclusion on this question is that his medical instinct rebels against the view that general paralysis is a *direct* consequence—a *direct* effect of syphilis ; and in no way does he qualify it as syphilitic in the sense that a chancre or a gumma is syphilitic ; for general paralysis, as an example (and there are other reasons, he adds), is in no way modified by antisymphilitic treatment. General paralysis he therefore classifies among the *parasyphilitic* affections, the characteristics of which are : *a.* That they do not exclusively and necessarily depend for their production on syphilis (tabes, rachitis, neurasthenia, hysteria, etc., are analogous in this respect), and *β.* They are not influenced by mercury and iodide of potassium as are true syphilitic affections.

4. Prof. Fournier disclaims any special ability or opportunity of giving a satisfactory answer to the 4th question, and it is in this connection especially that the assistance of workers in other fields is required. He has been struck, for instance, with the observation that general paralysis in his patients (syphilitic) often starts with phenomena of locomotor ataxy, or becomes associated with locomotor ataxy, forming a hybrid combination which he has called cerebro-spinal tabes. Frequently he has seen tabes end in general paralysis, and, again, tabes and general paralysis develop hand in hand, so to speak. Do cases of general paralysis of other origin present as often this combination of symptoms ? Probably not. However, he does not insist on this point, which he considers outside his province. And so with regard to the evolution of the disease, the remissions, the apparent cures, the duration, etc. "Be sure," he says, in conclusion, "the question of the relations of general paralysis with syphilis will only be thoroughly studied, elucidated, and, finally, judged in all its multiple, complex, and difficult bearings by the union, the collaboration, the syndicate (to use such a word) of alienists, pathologists, and 'syphiliographers.'"

A Case of Hysterical Anorexia.

Prof. Brissaud and A. Souques ("Nouvelle Iconographie de la Salpêtrière," No. 6, 1894), under the title of "Délire de Maigreur," relate the notes of an interesting case of hysterical anorexia in a girl aged 19 years, in order to illustrate its psychical origin, bearing out the more modern, and no doubt correct, view that hysteria is a mental disease.

A girl, aged nine, hereditarily predisposed, falls one day accidentally on her right hip; a painful swelling occurs, which soon disappears, but leaving a hyperalgesic spot (hysterical or of psychical nature), persisting for 10 years. By association of ideas other manifestations occur; tympanites, vomiting, fainting attacks. The patient being, in spite of this, somewhat stout, she was a good deal chaffed by school-fellows; hence arises the fixed idea of wasting. She begins by abstaining from food, and vomiting soon occurs. At the age of 16, the hip becomes worse, and a diagnosis of peritonitis even was made; fortunately her general condition was so serious that an operation, which was suggested, was not performed. She suddenly improved after the application of the cautery to the iliac fossa, but relapsed a little later to be cured again apparently by drinking Lourdes water. A few months later vomiting recurs, and the hip becomes again painful, but a pilgrimage to Lourdes is of no avail. She thinks she is damned, has offended God, etc., and she now is sent to the Salpêtrière (17th April, 1894). On admission the wasting was extreme—weight 29 kilogrammes. No disease of the hip (or signs of former disease) present; she is sad, apathetic, and preoccupied by ideas of culpability, of being damned, etc. She was isolated and threatened with the stomach-pump and began to eat. Within three months her weight increased by 30 kilogrammes; mentally she improved *pari passu*. The authors show how it is possible behind each episode of the varied course of this case to trace the determining idea. The enormous increase of weight under treatment can only be compared with the wasting preceding her admission to the hospital; it is possible that under suitable circumstances in hysteria the trophic influence of the nervous system is stimulated by the idea of putting on weight. There are two accompanying plates of the patient on admission and after treatment.

*2. Asylum Reports.**Some English County and Borough Asylums.*

Birmingham. Winson Green.—Mr. Whitcombe makes mention of the increase in melancholiacs among the admissions, and found no less than 128 out of 396 cases admitted to be actively suicidal. He mentions among possible causes of this condition "cramming," which "by forcing brains irrespective of their capacity up to certain standards, gives rise not infrequently to mental distress

and disturbance, and this may act either immediately by causing a breakdown, or more remotely by originating ambitions which are found in a large number of instances to be unattainable." As to the present system of gathering all classes of patients into one institution he remarks :—

The ages of those admitted varied from five to 84 years, 44 being over 60 years of age. The fact that it should have been found necessary to send a child of five years and a person of 84 into an asylum is not creditable, and shows a want, which I have before pointed out, of some proper accommodation for such cases.

It cannot be just to idiot children, nor yet to those acute cases of insanity for whom the institution was provided, that they should be mixed together under the same roof, while for a poor old creature also, who has passed the average of life by so many years, to be placed in a similar position can hardly be looked upon as a humane treatment of senility.

The patients of both sexes dine together, males on one side of a table and females on the other, and no fixed respect is paid to the dietary, all favourable opportunities being taken to vary the dinner, *e.g.*, as the Commissioners found on their visit, by stewed rabbits and bacon, with potatoes and haricot beans. We believe that the breaking down of cast-iron customs by such means as the above can take almost equal rank with pathological research in forwarding the curative treatment of insanity.

At *Rubery Hill* there is but little for Dr. Suffern to make note of, since his patients are almost entirely chronic. He can report, however, two recoveries after seven and twelve years' illness.

Seeing that the nature and stage of the insanity of the residents in these sister asylums varies so much, we think it may be of interest to reproduce a few corresponding figures :—

				Winson Green. Rubery Hill.	
Total cases under treatment				...	1,020
Average number resident				...	626
Admissions in the year				...	396
Of these were transfers from other asylums				...	12
Average age on				...	40·83
Duration of insanity less than one year				...	271
Duration of insanity more than one year				...	80
Caused by alcohol				...	56
Discharges (recovered and not recovered)				...	296
Deaths				...	90
Average age on				...	49·36
From phthisis				...	7
General paralysis				...	20
Percentage on average numbers resident				...	14·3
					6·14

The recovery rates can hardly be contrasted, and are not given here. The great divergence of the death-rate occurring in cases drawn presumably from the same sources, and residing under similar climatic and local conditions, affords convincing proof, if

any were wanted, of the enhanced mortality appertaining to acute mental disease.

Bristol.—Most Medical Superintendents have views similar to those so well put by Dr Benham on the subject of the extension of the 4s. grant.

Some of the cases referred to above might, I think, be equally well treated in the imbecile wards of a workhouse, but the union authorities have at present no inducement to make provision for cases of this character, as, owing to their receiving a capitation grant of 4s. for every case under asylum treatment, they can keep any patient chargeable to them in an asylum at no additional cost to themselves.

The proper remedy for this state of things has, in my opinion, already been suggested, viz., that the 4s. per week should be allowed to the union authorities not only for the patients in asylums as heretofore, but also be extended to any case at present under asylum treatment certified by the medical officer of that asylum as capable of being managed in a workhouse. This would encourage the workhouse authorities to supply suitable accommodation for cases of this kind, and benefit the asylums not only by relieving the congestion of their wards, but also improve the recovery rate by removing a portion of the dead weight of helpless and incurable patients, which experience has shown to be detrimental to the recovery of those amenable to treatment, whilst the asylum wards would be tenanted by the persons for whom they were originally built, viz., cases either capable of being benefited by treatment, or so violent or dangerous as to require special precautions for their safety.

We are not quite sure whether Dr. Benham looks for the extension in favour of future patients in the asylum who may become fit for transfer under section 25. We hope so, for the cardinal point in the proposed new departure is that only the Medical Superintendent shall have the power to say which cases are fit for residence in workhouses. If the Guardians receive the grant for patients retained by them and not forwarded to asylums for preliminary treatment and observation, the old mischief will assuredly follow. The criterion of removal to the asylum will be troublesomeness and not curability.

Carmarthen.—Our first duty in noting this report is to express our deep regret at missing in it the name of Dr. Hearder, who for 27 years ruled the destinies of this asylum. Though not known personally to the younger members of the Association, he was in former years an ardent and loyal supporter of it. Our next duty is to congratulate Dr. Goodall, his successor to the post of Medical Superintendent. He commences his work with a very full and elaborate report to his Committee, in which he gives evidence of extensive, sound and progressive knowledge of the matters placed under his charge. We have heard doubts expressed whether a Medical Superintendent's report should not be confined to a business-like statement of the transactions for the year made for the benefit of the County Council and other officials interested. But we hold very strongly the view that a Superintendent should never lose the opportunity annually given him of preaching—as he alone can preach in his district—the gospel of prevention and

the means to be taken to ensure prevention, as far as can be. The people have to be educated in these matters, as well as others. As we have stated before, the great object to attain is the awakening of all possible interest in the official mind, and this interest is sure to follow intelligent instruction in the elements of the question. Dr. Goodall has certainly spared no pains to arouse an interest in the minds of his readers.

Cheshire. Upton.—On December 31st, 1894, this asylum did not contain one case of general paralysis among its 617 inmates, notwithstanding it accommodates Birkenhead.

We extract from the report left by the Commissioners two statements:—

We also hear of lunatics who should be here, but who are accumulating in workhouses and elsewhere, and so losing a chance of recovery by early treatment.

We should be glad to see more extensive staining of floors to obviate too frequent scrubbing, which tends to introduce erysipelas.

Cumberland and Westmorland.—The Visiting Committee have definitely determined on the erection of the first house for private patients, and the plans have been prepared and approved by the Secretary of State. The buildings are in course of erection. Dr. Campbell shows a recovery rate of 51·8; two recoveries took place after five years, and one after ten years' residence. We think that in each case of prolonged and successful treatment a short *résumé* of the course would be of great service, especially if the Medical Superintendent would state whether it was, on the one hand, never regarded as hopeless, or, on the other, exhibited signs which pointed to permanent insanity.

A post-mortem examination was made in each of the 58 deaths.

Derby County.—Dr. Murray Lindsay's well-known energy in the matter of pensions has met with its reward in a "pension scheme as the scale for guidance of the Visiting Committee," which, he says, has given great satisfaction to the staff. In connection with this a valuable precedent has been established for granting a gratuity to the head attendant, Harry Bird, who died in office.

A subscription among the staff for the widow and family was very quickly set in motion, speedily followed by a village subscription fund; in addition to which, by the kind advocacy of the Committee, a sum of £150 was granted by the County Council, subject to the sanction of the Local Government Board, which has since been obtained.

The post of chief female head attendant having become vacant, a new departure has been made in the appointment of a lady, with some years of previous training in a general hospital. Dr. Lindsay says that he has every reason to speak favourably of her appointment.

Derby Borough.—We are glad to see that Dr. Macphail has obtained from his Committee the generous grant of £4 extra

wages for holders of the Nursing Certificate after five years satisfactory service.

In relation to the physical condition of his admissions, we extract the following from Dr. Macphail's report :—

Two-thirds of the admissions (64) suffered from recognisable physical disease. Each year we receive a larger proportion of patients exhausted from old age or advanced physical disease, and sent here merely to die. Over nine per cent. of the patients admitted died within the year, as compared with five per cent. among the admissions in 1893. One man was admitted in a dying condition, and only lived for four hours. He was suffering from advanced inflammation of both lungs, and in my opinion ought never to have been sent here. Another case in the last stage of paralysis died within a week, and a third patient, admitted from the infirmary after an operation for cancer, only lived a few weeks. From inquiries I find that these patients were sent to the asylum because there was no other course available, and in all of them the evidence of certifiable insanity was meagre in the extreme. These are not isolated instances in the history of this or any other public asylum, and it is perhaps desirable in the interests of humanity that our doors should be open to receive such cases, but facts of this kind should be borne in mind when we hear of the large increase of insanity that has taken place in recent years. The truth is that the limits of certifiable mental disease are yearly widening to include the most temporary mental aberration in the course of any physical disease, and the public have increasing confidence in the nursing resources of asylums, and are well satisfied to allow their aged relatives to be nursed by us in their "second childhood."

Devon.—A pension scheme for the officers has been established. Not more than 1-40th or less than 1-50th pay and emoluments is allowed for each year's service, the restrictions laid down by the Act being, of course, observed. The variation allowed for difference in value of service tends to obviate the one weak point in a fixed scheme—a dead level between the rewards of a good and mediocre officer.

Dorset.—Dr. Macdonald notes a large amount of acute mania among his admissions, larger than is usual in rural districts. He is not one of those who will accept the soothing plea that the increase in the number of lunatics is due to accumulation. He states that the incidence of the disease is increasing in Dorset. This he attributes to the stagnation of village life, leading to much intermarriage between families having hereditary predisposition. We trust that Dr. Macdonald will make further study of the statistics at his command, and that he will develop his argument in the pages of this Journal. He has induced his Committee to give medals for continuously good service—bronze for five years, silver for ten, and gold for twenty-one. Needless to say much satisfaction is produced. Any step like this, which tends to promote an honest pride in service, is to be heartily commended.

Essex.—Great pressure on space here has led the authorities to add another to the number of private houses taken over for the accommodation of patients. Such a course seems to be very commendable for various reasons. If, as in this case, there is a

certainly sooner or later of a large borough in the county removing its patients to accommodation of its own, the necessity for providing new permanent accommodation is tided over. Further, it helps to fill up the terribly wide gap between the asylum, with its necessarily restrictive discipline, and the work-house with all its pauper associations. We have heard the argument used that these private houses drain off the patients who contribute so much to the routine labour of an asylum. But Essex seems to prove the hollowness of this view, for it now has three such houses, containing respectively 49 females, 53 females, and 75 males; 177 patients, out of a total number of 1,436 on the books on December 31st.

We note that local physicians carry out the daily visitation of these branch houses, though, of course, Dr. Amsden is primarily responsible for the efficient administration.

Glamorgan.—Dr. Pringle devotes a considerable part of his report to the subject of general paralysis, and seeing that he has year by year a far greater opportunity of studying its causation than most of his colleagues, his views command great respect.

Particularly is this the case in regard to that acute and rapidly fatal form of nervous disease, general paralysis. In the five years 1882-6, this variety constituted 7.1 per cent. of the admissions, but during the past five years the proportion has risen to 15.2, and this increase is half as great again in females as in males.

Of all forms of insanity heredity plays the smallest part in the causation of this particular variety; its origin lies mainly in causes which are to a very large extent within control, and is not to be found in altruistic strife and stress of life, the struggle for the good of others, or the awakened conscience of the present day, which will not tolerate unkindness or cruelty to man or beast, but in self-indulgent yielding to and perversion of natural instinct, and excesses of all kinds. An examination of the tables given in the reports of the Commissioners for England and Wales shows that excesses—alcoholic and sexual—form far and away the most prominent features in the immediate causation of insanity, and greatly more pronounced is this the case in general paralysis. Marked as this is as regards the whole country, it is, I regret to say, much more so for this county, as the following figures show:—The proportion of general paralytics per cent. of pauper admissions in England and Wales during the five years 1888-92, was for males 15, for females 3.7, total 9.1; but in Glamorgan the rate stands at 21.8 for males, 6.7 for females, total 15.2. Alcoholic excess is assigned as a cause of insanity in the pauper admissions during a like period as 21.1 for males, 8.3 for females, total 12.8; whereas for Glamorgan it is for males 36.0, for females 13.7, total 26.3; and as a cause of general paralysis in England and Wales it shows a percentage on admissions of males 26.1, females 20.1, total 24.9, as compared with Glamorgan, males 40.0, females 37.5, total 39.5. The foregoing afford sufficient evidence of the closeness of association of one form of excess with insanity in general, and its nearer relationship still to general paralysis in particular. A similar, but less pronounced, relationship exists as regards abnormal sexual excesses, though in practice it is found extremely difficult to obtain reliable information on this point in the history of the admissions.

As will be seen Dr. Pringle holds very much to the theory of vice-causation. Experience gained year by year leads, we think,

to increasing doubt whether the breach of moral laws in the coarser directions is quite so active in the production of the disease as has been maintained in earlier days. Scientifically the question is of course of great importance, but it also has most serious social bearings. If death from general paralysis is to be construed as presumptive death from vice, a very considerable number of those who have apparently walked in godliness will leave this world with damaged reputations.

We think that some of Dr. Pringle's figures weaken the contention. From 1882-6 7.1 per cent. of the admissions were paretics; during the past five years the average (15.2) has more than doubled. Can it be for a moment maintained that the people of Glamorganshire have become twice as wicked in such a short space of time? We are constrained to look for other contributing agencies, the more so since general paralysis being essentially a disease leading at its commencement to lost control of the passions, it is probable that in many cases vice is a symptom more than a cause.

We would also point out that the less frequent assignment of hereditary predisposition to general paralysis by no means goes to prove that the disease is therefore more personally acquired. The statistics relied on have regard to predisposition from insanity. Looking to the causation of other neuroses, epilepsy for example, it would be proper to assume parental failure in other neurotic directions.

In analysing Tables X. and XI. we find that sexual intemperance was assigned in two men and nine women, the percentage for women being 6.7, or nearly ten times the five-year average for paupers in all England and Wales. Three prostitutes and eight female general paralytics were admitted.

Gloucester.—Mr. Craddock continues to pay great attention to the statistics of his asylum. We notice that he does not adhere entirely to the tables of the Association. This, to our mind, is a pity, for instructive as his figures are they would be still more useful if they could be readily collated with those of the great majority of asylums. For instance we cannot find the tables dealing with the ages, or the duration of insanity on admission, nor indeed a concise statement of the form of insanity on admission, though the latter can be arrived at after considerable study of the highly detailed table of the physical condition of those admitted.

Mr. Craddock is very averse to withhold beer from his patients.

I hold strongly that a man who has done an honest day's work on farm and garden, or a woman in kitchen or laundry are entitled, if they wish it, to a moderate allowance of beer, and that they are not only none the worse but decidedly the better for it.

The Visiting Committee remark in their report:—

The Committee are pleased to be able to state that an increased number of

Boards of Guardians have this year visited the asylums, but they regret that 11 out of the 24 have not found it convenient to do so. Many of the patients who have been resident for some years receive no visits from their friends, and the only persons whom they can hope to interest in their welfare (apart from the Committee of Visitors) are the members of the Boards of Guardians of the different localities in which these poor patients have formerly resided.

And the Commissioners also state :—

One of the London patients seems, as far as we could ascertain, to have a valid grievance. He, H. L., was transferred from Cane Hill, where he says he was visited every fortnight. If this be the case he should be returned to Cane Hill, and some friendless patient sent in his place.

Some Registered Hospitals.

Barnwood House.—Dr. Soutar has had better fortune than most people in obtaining history as to hereditary predisposition, for he has ascertained hereditary predisposition in nearly three times the proportions of the Commissioners' five-year tables.

An hereditary tendency to mental disorder has been ascertained in 63·6 per cent. of the cases admitted during the year. Many causes, more or less speculative, have been alleged as exciting the attacks of insanity, but as usual we have found that in a large proportion of the cases the development of mental manifestations has but marked a stage more or less advanced of a progressive deterioration of the general health.

We think that a great service might be rendered by any one who has the opportunity and zest for so doing, if he would work out a considerable number of cases in relation to hereditary predisposition. The optional table of the Association, which is given by few, is of little use except for recording the number of cases in which hereditary predisposition has been assigned. What is really wanted is a record of the *volume* of hereditary predisposition in a particular case, and a closer connection between volume and particular forms of the insanity and other material points.

Bethlem Hospital.—Remarks made by Dr. Percy Smith and the Commissioners as to the large proportion of melancholic cases admitted into this institution, together with Dr. Smith's observations in the subjoined paragraph, have tempted us to collate certain statistics contained in this report with those of St. Anne's Heath and the five-year tables of the Commissioners.

Next to the two great heads of hereditary influence and previous attacks, "domestic trouble," "adverse circumstances," and "mental anxiety and worry" were the most important factors in causing insanity in those patients admitted during the year: these groups together accounting for 79 cases, or 32·8 per cent. In the forty-eighth Annual Report of the Commissioners in Lunacy, these three groups together account for only 18·7 of all the cases admitted into asylums and hospitals for the insane for the five years—1888 to 1892. In the case of private patients as distinguished from paupers the percentage, however, is given as 24·5. The larger figure shown in the cases admitted here is probably accounted for by the fact that our patients belong principally to those classes in which the struggle for existence is most keenly felt, namely, the various groups of educated people of very limited means, clerks and governesses usually forming a large proportion of our admissions.

	Bethlem.		St. Anne's.		Commissioners' 5-year average Private Cases.	
	M.	F.	M.	F.	M.	F.
Admissions 1894 ...	94	147	82	94	1129	1040
Proportion of admissions to average residence ...	100%		50%		—	
Percentage of recoveries ...	54.2	53.7	42.6	63.8	—	
Percentage of admissions in which there was found causation by domestic trouble, adverse circumstances, and mental anxiety, worry, and over-work ..	41.5	27.02	39.0	25.5	26.8	23.8
Hereditary predisposition ...	49.0	45.4	11.0	18.0	21.5	28.1
Mania (all forms) ...	31.9	30.6	53.6	62.6	42.0	46.9
Melancholia (all forms) ...	39.3	60.5	13.3	24.4	25.7	34.0
General paralysis ...	17.0	1.36	12.5	3.19	12.9	1.1

The disproportion in the cases of mania and melancholia as between the two institutions is very striking, and equally remarkable is the inverse departure from the mean averages in the Commissioners' tables. Looking at the occupations of the admitted patients (Table XII.), the struggle for existence with limited means is evidently more keen in the Bethlem patients than in those of St. Anne's. The disproportion in the assignment of hereditary predisposition, though remarkable, is not of the slightest value for founding any conclusion. Probably if mendacity could be tabulated the proportion would be the other way. It is curious that the statement as to hereditary predisposition which has to be made (theoretically under penalty for inaccuracy) is still so widely evaded.

The following note is worthy of preservation:—

One man who had previously been in an asylum abroad, hailed a cab in the street and said to the driver, "Drive me to an asylum," his sense of impending mental disease impelling him to take refuge in some such institution. Shortly after his admission dangerous homicidal tendency developed, and it became necessary to detain him under certificates, though he seemed so typically a voluntary patient that it was delayed as long as possible.

The Coppice, Nottingham.—There is much solid comfort in the domestic arrangements of this hospital, and were its management better known, there should never be a vacant bed. The payments are moderate; what is regrettable here is the difficulty found in enlargement of the grounds attached to the hospital, which do not exceed 17½ acres; the liberality of the Corporation, which owns the adjacent land, should be equal to an extension of the grounds of this truly charitable institution.

We cull the above from the report of the Commissioners on one of their visits, and remark with surprise, that though this is a truly charitable institution, in which the balance of receipts over expenditure is slender, in which every penny received from

patients, together with a considerable portion of the limited receipts from investments, etc., is spent on the patients, in which the year's ratio of recoveries is above and the ratio of deaths is below the average for hospitals, and in which are to be found just those patients for whom charitable institutions were founded, there is yet no detailed statement of or even a hint at the amount of charitable work done. Indeed, only by collating with the Commissioners' report can we find that nearly 50 per cent. of the patients cost more than they pay, and that the profit on each of those who pay more than their cost is limited to the magnificent amount of 3s. 4 $\frac{1}{4}$ d. per week.

Some Scottish Royal Asylums.

Aberdeen.—The principal feature in this report is the description of the new hospital, which was nearly completed at the end of the year, and should now be quite finished. A satisfactory knowledge of its general arrangements can be obtained from a scale plan, amplified by a carefully prepared description. It is proposed to combine therein various views of what an asylum hospital should be; that is to say, part of it is for mental observation of recent hopeful cases, part for infirmary cases, and yet another small part for infectious disease. The whole building seems to have been designed so as to procure the greatest possible amount of light, ventilation, and space for the inmates. There are covered conservatories and areas, long and broad corridors, duplicated in the centre, and we calculate that the cubic capacity of the day accommodation is 500 feet per patient and in the dormitories upwards of 700. Electric lighting is to be used throughout. The total accommodation is for 150 patients, being about 23 per cent. of the *present* average in residence. The food will be supplied from the central asylum, from which the hospital is about 130 feet distant. An associated dining-hall is provided. The only point in the general arrangement on which we have doubts is the propinquity of the infectious blocks. These are at each end of the building, separated by about 25 feet of passage; but the connecting doors can be shut and cross access doors in the passage can be opened. But bacteria are wonderfully locomotive beings, and some communication must be kept up by the bringing backwards and forwards of sheets, cooking utensils, and food. We should have thought that it would have been wiser to have built a separate independent house, with its own kitchens and necessary disinfecting conveniences at a considerable distance.

We shall be much interested to hear later on how the warming arrangements succeed. These are to be on the Sturtevant principle. Air is admitted through regulating louvres, screened from soot and impurities by wire canvas, heated by steam coils and finally *propelled* by a fan along a huge trunk of 36 inches

square, from which branches radiate to the blocks. From these branches the air is taken by fire clay pipes to the various apartments and delivered in to them with carefully regulated velocity at a height of eight feet from the floor. A corresponding amount of ventilation by air outlets and fireplaces is provided. In summer the air comes in in the same way (subvented by the opening of the window sashes when necessary), but the steam is turned off from the heater. No doubt provision is made, though not detailed in the account, for insuring that the distribution of heat between all rooms far and near is fairly equable. We should have liked to have heard how much heating space is provided on the steam-coils, for this we take to be an essential to success. A small superheated space must assuredly lead to "cooking" of the air, the impression of which cannot be easily got rid of by dilution.

The other parts of the report betoken much energy and progress. Dr. Reid has strong views as to the all-powerfulness of heredity, and attempted to make minute inquiry on this point in each new case, but was defeated by *suppressio veri* on the part of relatives.

Edinburgh Royal Asylum.—As usual, this report contains interesting matter and plenty of it. The great event of the year was the opening of the new Craig House by the Duke of Buccleuch. Some of the outlying villas were occupied, but the removal of the patients to the main building had to be postponed till this spring on account of the severity of the winter. The *finis* of the work has brought the usual *corona* of exceeded estimates, but what is that to Morningside? The Visiting Commissioners speak very warmly of the comfort and efficiency of the accommodation taken up at the time of the report, and when the whole is in working order we are convinced that the North of England will be tempted to send its contribution of affluent inmates, and thus help to give financial stability to this great venture.

Dr. Clouston coincides with the Scottish Commissioners in their views of the absence of proof that insanity, as an occurring disease, is on the increase. While giving due allowance in causation to physical ailments and badly managed normal *crises*—such as puberty, adolescence, the climacteric—he strongly insists on the pernicious effects of bad brain hygiene.

Little may make the difference whether an originally sensitive and highly imaginative brain becomes, under bad conditions, insanely delusional, or under good ones, brilliantly imaginative. Many such brains well worth taking care of are now lost to the world through bad conditions.

General paralysis continues to contribute in increasing quantity its formidable quota of incurable fatal admissions, the males being close on 20 per cent. and the females nearly three per cent. Dr. Clouston gives several probable causes—high pressure, debauchery *sometimes*, overwork, etc. We would suggest a geographical predisponent in the shape of Edinburgh's seaport Leith. In

looking over asylum statistics from year to year, we have been much struck with the high percentages of this disease in districts consisting of or comprising busy seafaring communities. As instances, we can give Hull, Newcastle, Bristol, Portsmouth, Glamorgan.

Dr. Bruce's successful introduction of thyroid treatment in cases other than those of myxœdema is referred to with warm approbation, and his subsequent receipt of the University gold medal for his thesis on this subject is recorded.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

GENERAL MEETING.

A General Meeting of the Association was held at 11, Chandos Street, London, on Thursday, November 21st, 1895, David Nicolson, M.D., President, in the chair.

This was the first statutory meeting since the incorporation of the Association, and according to the Companies Acts, 1862 to 1890, the first meeting must be held within four months of the granting of the Certificate.

The minutes of the last General Meeting (held on May 16th) having been read and approved,

The PRESIDENT said that, before beginning the ordinary business, he might be allowed to say a few words about one of the oldest members of the Association, who was that day laid in the grave. Dr. Jamieson, of Aberdeen, lately the oldest Asylum Superintendent in Scotland, was a man of singular capacity, who, though but little known to the junior members of their specialty, in his day did a great work in bringing his asylum up to the standard, while his writings and lectures were well worth perusal, even in the light of the best work of recent years.

ELECTION OF MEMBERS.

The following were declared to have been duly elected:—William Bubb, M.R.C.S., L.R.C.P.Lond., Second Assistant Medical Officer, Worcester County Asylum; Arthur George Ewbank, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Middlesex County Asylum, Tooting, S.W.; George Baths Griffiths, M.R.C.S., L.R.C.P.Lond., Assistant Surgeon, H.M. Convict Prison, Portland; Frederick Walter Mott, M.D., B.S.Lond., F.R.C.P., Pathologist, London County Asylums, Assistant Physician, Charing Cross Hospital; Gilbert Edward Mould, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Peckham House, S.E.; Margaret Cochran Dewar, M.B., C.M. Univ., Glasg., Assistant Medical Officer, Crichton Royal Institution, Dumfries.

LATAH.

Dr. W. GILMORE ELLIS read a paper on "Latah," which will be published in a future number of the Journal.*

Dr. COOKE referred to Mr. H. A. Forbes' book, "A Naturalist's Wanderings in the Eastern Archipelago," in which almost all the symptoms alluded to by Dr. Ellis were clearly described, and instances of several cases were given. Mr. Forbes regarded it as being of a hysterical nature, and mentioned that it was chiefly found among women, although occasionally men were affected by it. He also pointed out, as Dr. Ellis had done, that the onset of the attack was due to the person being startled by some object of terror, or by being suddenly excited. The marked tendency to imitate other people on the part of the subjects of *latah* was also well illustrated by Mr. Forbes. According to him the condition varied in degree, so that whilst some were utterly incapacitated by it others were only

* But see "Journal of Mental Science," Vol. xli., pp. 537 and 728.

slightly affected, as, for instance, in their walking. A curious case described by Mr. Forbes might be quoted:—"On one occasion, while eating a banana, I suddenly met a servant (the subject of *latah*) with a piece of soap in her hand, and perceiving she was slightly *latah*, but without appearing to take any notice of her, I made a vigorous bite at the fruit in passing her, an action she instantly repeated on the piece of soap. On another occasion, while she was looking on as I placed some plants in drying paper, not knowing that caterpillars are objects of supreme abhorrence to the natives, I flicked off one in a humorous way on to her dress, one that happened to be on a leaf; she was instantly intensely *latah*, and, throwing off all her clothing, she made off like a chased deer along the mountain road, repeating the word for caterpillar as she ran until compelled by exhaustion to stop, when the spasm gradually left her." Other incidents described by Mr. Forbes ran as follows:—"My own 'boy,' who would unconcernedly seize all sorts of snakes in his hands, became one day *latah* also on suddenly touching a large caterpillar. My host's maid once, while alone at some distance from the house, having come unexpectedly on a large lizard—the Baiawak—was seized by a paroxysm; dropping down on her hands and knees to imitate the reptile, she thus followed it through mud, water, and mire to the tree in which it took refuge, where she was arrested and came to herself." Another case which came under his notice was more tragic in its results. "This woman, startled by treading in a field on one of the most venomous snakes in Java, became so *latah* that she vibrated her finger in imitation of the tongue of the reptile in front of its head till the irritated snake struck her, and the poor creature died within an hour." Mr. Forbes does not go into the pathology of the disease; but, as so little was known about the affection, he (Dr. Cooke) thought it would be interesting to the Society to have these notes brought under their notice.

Dr. MERCIER thought it matter for congratulation that the Association should have had such evidence that its ramifications extended to the far East, and that a gentleman from so distant a quarter should come to give them an account of a disease of which most of them had not even heard before—a disease which, he thought, was unique and had very few, and those not very close, relationships. As far as he could judge from the clear account which Dr. Ellis had given, its nearest relationships were with hysteria and with hypnosis; but they could certainly rest confident that it was identical with neither of these. The most curious and striking sequel of the malady was the extraordinary tendency to imitation. This was a tendency which was very deeply ingrained in the human race, and also in its ancestors. It was well known how exceedingly mimetic were almost all the races of monkeys, and it therefore seemed to him that in this malady they had a recrudescence and an exaggeration of this ancestral peculiarity. It was a fact well known to biologists that when an ancestral faculty which had been in abeyance for many generations was revived, not only did it become exaggerated, but it also took on morbid manifestations. He made this suggestion in explanation of the pathology of this very peculiar disease.

Dr. MICKLE thought, from Dr. Ellis's account, that *latah* had certain physiological relations with some conditions known to them, and an absolute identity with other diseases which had been described in different parts of the world. It appeared to him that, besides certain hypnotic conditions and certain cases of hysteria, it had other affinities. He would say in reference to a remark made by Dr. Ellis that "hysteria was very rare among the Malays"—that most nervous diseases had peculiarities which were impressed upon them by the races in which they arose; and that they did not expect to find all nervous diseases, particularly those of a functional character, quite the same in the red man as in the black; at all events, if they expected it they did not find it. Among the other conditions to which, he thought, *latah* had not very remote relationships, were the whole series of morbid impulses, the impulsive conditions which arose in various forms of insanity in which "impulse" constituted practically the morbid condition. And in this connection he thought the relationships were not very distant between the disease which had been described to them and those conditions known to them as being impulsive acts connected with so-called "imperative ideas." For example,

he had noticed in Dr. Ellis's description several cases in which there were distinct varieties of that peculiar condition found in Europeans called onomatomania, an affection which, though it did not constitute insanity, did certainly in some cases pass into it. This condition, where words had such an extraordinary effect upon some individuals, found its germ in the peculiar mystical meanings which had been attached to certain words. Some of them ascribed an extraordinary significance to the name of the person. Others considered that in some way the divinity was wrapped up in certain words or forms of words; while by others extraordinary significance was attached to certain sounds. With regard to the *identity* of this disease with other conditions which had been described, he believed that *latah* was precisely the same disease as that which obtained in North America among certain savage tribes, where it was called "the jumping disease," and its subjects were called "jumpers;" precisely the same disease as had long ago been described as existing in Siberia under the name of "meryachit." The imitiveness of the subjects of the last-named (most important in *latah*) was found not merely in hypnosis, but also in mental derangements which constituted a reversion in type.

The PRESIDENT said the paper covered a very extensive range, not only in its suggestiveness, but also as regards the natural history aspect. He thought that before they could pretend to understand a disease of that kind they had to surmount the great difficulty of attaining to a knowledge of the peculiar mental disposition and characteristics of the Malays, and the races near to them, and the country in which they lived. Then followed the question of individual modifications that might arise in one case or another. They could not expect an exact reproduction to all time of the original form in which a disease or a peculiar mental condition showed itself. It seemed to him further that they had to consider the influence of heredity, and how far, apart from the mimetic faculty, and without premeditation, this derangement was a matter of education through family habits, so that what would seem very strange to us might not seem to them so striking a deviation from the normal. No doubt the imitative propensity, the determination to follow out a suggestion made by another person in the presence of the affected individual, supplied a clue in the direction of what Dr. Mickle had referred to as the mystical element in such conditions, and he thought the ultimate outcome of the study of *latah* would show that there was some religious basis underlying the affection which they were unable to explain, unless Dr. Ellis could tell them how far the compelling influence of religious belief could be traced. The subject was one which merited very close attention. He thought it was likely there was a very large substratum of simplicity of mind without actual weakness of mind, such as was generally ascribed to the Malays—a simplicity of mind which rendered them very susceptible to external influences and apt to be thrown into a state of profound agitation. Some element of that sort, as Dr. Ellis himself had suggested, was no doubt at the root of the extravagant demonstrations and of the morbid sensory phenomena. They had great reason to be grateful to Dr. Ellis for bringing so obscure but at the same time interesting a subject before them.

Dr. ELLIS, in reply, thanked the members of the Association for their patient attention, kindly criticisms, and for the suggestions with regard to future work on the subject. Dr. Cooke had more especially mentioned hysteria. Anything like hysteria as it was understood in England he had never seen in the Malay race. If *latah* were hysteria it was quite a distinct form from that met with at home. In his experience throughout the Malay Peninsula he had never come across any case incapacitated for ordinary work. Dr. Mickle had mentioned "meryachit." In the course of his paper he had spoken of Hammond as having already described "meryachit" and *latah* as, to all intents and purposes, one and the same disease. As to *latah* being a form of degeneration, he did not think it was so. He had come across *latah* subjects who were certainly as able as any Malays. In reply to Dr. Seymour Tuke, all *latah* subjects he had met carried on their everyday work just like other people, and the Malays themselves did not look upon *latah* as being allied to insanity in any way. They excused certain peculiarities. In his paper he had used the word *latah* in the broad sense in which the Malays

used it, without going into any classification of the forms of the disease. He had certainly described some cases as being imitative and others not. On that point he hoped to be able to do some further work, and was, therefore, not then prepared to make further comment on it. *Latah* was just as frequent in the present day as forty or sixty years ago, when the Malays were absolutely uneducated. Now they had British-taught schools throughout the peninsula, and many of the young Malays wrote and spoke English. With regard to religion, the Malays for the last three or four hundred years had been strict Mohammedans, and he had certainly never seen nor heard of religion mixed up in any form with the condition. As to treatment, he had never had an opportunity of trying any, and he had not the slightest idea of how one would set to work, except by having the patient in an asylum under the ordinary conditions. These subjects did not come into asylums. The only *latah* subject in his asylum of 400 people was the nurse to whom he had referred, and she certainly was the best nurse in the place.

Dr. Morrison's paper was, by his own request, deferred till a subsequent meeting.

MEETING OF THE SCOTTISH DIVISION.

A meeting of the Scottish Division was held in the Royal College of Physicians, Edinburgh, on 14th November, 1895, Dr. D. Nicolson, President, in the chair. There were also present Dr. Campbell Clark, Dr. Carswell, Dr. Cowper, Dr. C. C. Easterbrook, Dr. Fox, Dr. John G. Havelock, Dr. R. D. Hotchkis, Dr. W. W. Ireland, Dr. J. Carlyle Johnstone, Dr. J. M'Pherson, Dr. T. W. M'Dowall, Dr. Rutherford M'Phail, Dr. James Middelmiss, Dr. L. R. Oswald, Dr. G. M. Robertson, Dr. J. B. Ronaldson, Dr. Batty Tuke, sen., Dr. A. R. Urquhart, Dr. W. R. Watson, Dr. G. R. Wilson, and Dr. A. R. Turnbull (Divisional Secretary for Scotland).

THE PRESIDENT—It is a great pleasure, gentlemen, to me to be here with you to-day, as this is the first occasion on which I have been present at one of our national gatherings, and I need not say that I am very proud to be in the position which I have the honour to occupy. I will now ask the Honorary Secretary to read the minutes of the last meeting.

The minutes of the last meeting held at Glasgow were then read and approved.

PLACE OF NEXT MEETING.

DR. TURNBULL—The next Spring Meeting is the meeting referred to in the minutes just read, which it was suggested should be merged in a General Meeting of the Association, and we have to consider if there is any place that might be suggested to the Council and selected for the meeting. The fixing of the General Meeting depends upon the Council, but I suppose they (the Council) would not object to our making a suggestion on the point.

After some conversation, it was decided that the Spring Meeting be merged into the General Meeting of the Association, if the place fixed upon for the latter was convenient to the Scottish members, otherwise that they should hold their own Spring Meeting in Glasgow as usual.

REPORT BY THE COMMITTEE ON CRIMINAL RESPONSIBILITY.

THE PRESIDENT explained the circumstances under which the Committee was formed, and the lines upon which it had gone, and continued as follows:—In considering the report made by the Committee on Criminal Responsibility, you will see from the circular it is suggested that the discussion should take notice of the legal procedure in the different forms of minor crime, as well as in capital offences, in which the question of insanity arises, and should include reference to cases which are disposed of without asylum committal.

DR. IRELAND—I was quite pleased with the report, as the Committee agreed to do nothing. I always consider it a dangerous thing for medical men to expose their flank by going before Parliament, as I generally observe that such proceed-

ings result in shackles being put on the medical profession. Hence I am very much disposed to let matters stand. The judges at present are very well disposed to allow the voice of medical men to be heard in these important matters. The distinction that you make in considering, not only capital offences, but smaller crimes, is very noteworthy. It is evident that the man who commits a capital crime generally gains by being insane, as it is much less grievous to be put in an asylum than to be hanged; but it is a very different thing if a man who has committed a small theft is declared insane, and is committed until he has recovered from his insanity. It may be said that he is much more severely dealt with than the other. I am quite unprepared to speak on the general question, because, like most medical men, I like to get a concrete instance. In fact, insanity is a conception of the human mind. There is no such thing as insanity itself. It is a mere abstraction, and it would have been a more instructive debate if we had heard a paper giving the history of interesting cases.

The PRESIDENT—I am bound to say, as Dr. Ireland has put it, that the judges are certainly much more disposed to come round and see with us, and if they have before them a medical man whose opinions they can rely upon, they are always willing to listen and act in accordance with them. As one of the judges in the High Court of England wrote to me the other day: "Our legal rule is too narrow, and your medical rule is too wide, but I can always find, when I have a case before me, a way of getting round our narrow rule." These are his own words, and with the exception of a few judges, I believe they express very well the tone and feeling that they have with regard to this question. Again, it is very difficult to formulate a general rule that may not be mutilated when you come, as Dr. Ireland suggests, to the concrete instance. The difficulty is to please the lawyers and to satisfy medical men, and to compel, as it were, a just decision. We can all find cases to criticise where something was or was not done that we in individual cases might think could have been done; and it is for you to bring forward cases, that they may be analysed in the light of any change that may be suggested in the rule that is laid down by the judge to the jury, and if a sufficient case is made out I am sure that the Association will be prepared to give it a hearing, but unless you choose to mention the kind of case and the kind of difficulties it is impossible for them to be thrashed out in the complete way that an important matter of this sort demands. I have rather spoken in an explanatory sense, because I feel that there would be great risk in altering the ruling of the House of Lords judges, and unless we have a strong case, and unless we are unanimous, it would be puerile for us to go forward with any suggestion. I am bound to say that there is a great difficulty in dealing with the two questions bracketed on the circular, because in a capital case you hang the man rightly or wrongly, and it is done with, but in minor offences the man goes to prison, where he is probably very much better off than before. The bulk of the lower criminal class are well cared for in prison, and if there is any insanity the earliest possible opportunity is taken of dealing with them, so that, to my mind, a consideration of the one set of cases and a consideration of the other set of cases must be based on different possibilities and different practice and results. It is well to keep the two classes as far as possible apart.

Dr. BATTY TUKE—Some years ago a legal friend and I worked together for two or three years on this subject, and prepared a conjoint work on the medical and legal relations of insanity. Unfortunately my friend died, and I have never had the heart to look at the manuscript since. We began with as strong a feeling on the subject as anyone who has spoken in this Association—a strong feeling against the illogical nature, as we conceived it, of the criterion of right and wrong, but after going over the whole subject most carefully, although we found a certain proportion of cases in which injustice had undoubtedly been done, we came very reluctantly to the conclusion that for all practical purposes the present criterion was the only one that could be adopted. We all know the historic cases of injustice. I recollect one thirty or forty years ago—the case of a man who undoubtedly, had he lived at the present moment, would not have been hanged. I refer to Bryce, an epileptic of a very insane family. I think his great-grand-

father had been executed for a crime when he was probably insane. But times have greatly changed since then, and the medical profession in this matter have made a much greater impress not only upon the public, but also upon the judges and on the Home Office. I think the result of investigation has been that in the large number of cases considered by the Committee no instance can be adduced of a man having been hanged who should not have been. Undoubtedly the arrangement is a cumbrous one, but it has this to be said for it, that it has produced good results. The general feeling is that if capital punishment were done away with the matter is comparatively of very small consequence, because a man committed to prison passes a test of his sanity. He is subjected to the best test. If he is sane, well and good, and if he is insane he is not hanged. I don't think it is worth while discussing the question of minor offences. There may be cases of hardship, but taking the general working of the administration of justice in Great Britain we find that no great harm is done by the present system. It has been suggested that assessors to assist the judge should be appointed, but friends of mine now on the Bench say that would be unworkable and contrary to the whole principle of our law. Although there may be cases of shipping accidents where an assessor is allowed, that is an extremely technical matter, and no judge could take it as a criterion. In a matter of medical psychology the judge says that he is as good a judge as the medical witness, more especially when he is assisted by the medical witness in the box. My impression is that things should be allowed to remain as they are.

Dr. URQUHART—This is a very important question for us, and I hardly think that the abrupt conclusion of the Committee is commendable. Something should be done. I think that we should once and for all discredit the McNaghten questions. The only man who has tried to rejuvenate them was Sir James Fitzjames Stephen, and we must all remember that Dr. Maudsley has lately shown that the fine metaphysical distinction involved in his interpretation of the word "know" is such as to be beyond the working intellect of the average British juror. I think, at the present moment, if nothing is done we are debarred from any future objection to those famous questions which were answered as well as the knowledge of the time permitted; even to-day we would not be entitled to go very much further with the knowledge we have since acquired. We are in a transition stage; it would, therefore, be inadvisable to make ourselves the jest of future generations by laying down an exact rule on the subject. But I do think that the Committee ought to have gone further, and to have said that these questions are not the questions which should be put, that the time has gone by for them. I am sorry Dr. Yellowlees is not present, as he might have told us about the case of Laurie, the Arran murderer. Laurie was condemned to death, and after his condemnation a small jury of psychologists was appointed, who in effect revised the whole proceedings and found that man not guilty.

Dr. IRELAND—They found him insane.

Dr. URQUHART—No, they found that the whole circumstances were such as to indicate a certain amount of mental fatuity, and that, although he was deserving of punishment, he was not a subject for the extreme penalty of the law. For the first time in the annals of Scottish legal procedure, I believe, mitigation of penalty on account of fatuity not amounting to insanity was introduced. I think, therefore, that the report of the Committee is imperfect—imperfect in not entirely discrediting the McNaghten questions, and in not recommending a particular judicial authority for the reversal of death sentences. It seems to me that questions of criminal responsibility cannot be confined to capital cases. A great deal of misery is induced by insane criminals whose crimes are less startling, and the incidence of that misery often falls upon respectable people and leaves them in poor or depressed circumstances. Still, with all the homicidal and suicidal cases admitted into our institutions, the small number of criminals is surprising. So many, by mere accident or opportunity, might have become criminal, and yet how few pass through the Courts. I must apologise for making reference to statistics so limited in scope, and dealing with private patients only, but I find that in the sixteen years of my work in Murray's Asylum there were

538 admissions, and of these only ten have come under the cognisance of the police. Never once has Section 15 of 25 and 26 Vic., cap. 54, been put into operation in Perthshire to my knowledge. I have never known the Procurator Fiscal advertise that a case was to be tried before the Sheriff, and proceed to extremities under the section I have referred to.* We have always found that the Inspector of Poor, or the friends, intervene, and undertake the responsibility of placing the person under proper care. There is really very little to say with regard to those police cases. One was a thief by habit and repute, and was punished by imprisonment, but soon sent to an asylum as insane. Another was a case of sexual indecency, tried in London. He was sentenced to two years' penal servitude (the maximum penalty), so that he might be kept out of the way as long as possible. But after a few months in gaol a petition was got up, and he was released under proper safeguards. I think that we ought to consider whether these weak-minded criminals are properly dealt with. I don't believe they are. Both sides of the House of Commons are pledged to action, and we ought by all the weight of our influence to induce a proper appreciation of the condition of weak-minded habitual offenders, and secure proper means of dealing with them.

Dr. CARSWELL—Mr. President, I am sorry that I have not been able to put in written form all that I would like to say on this subject, because it is an important subject, and because one does not wish to take up the time of this meeting longer than is absolutely necessary. It so happens that I can speak of thirteen cases of serious crime in which I have personally been engaged at the instance of the Crown—all of them occurring within the last three years. Four were found insane by the judge in bar of trial. They came before the High Court, and a plea of insanity in bar of trial was set up, and accepted by the judge. That procedure is a very simple one, and it only requires the judges to be satisfied. There is in Scotland no question submitted to a jury; there is no jury. In three cases the prisoners were found insane after trial. The jury returned a formal verdict—to the effect that the prisoner was insane at the time the crime was committed, and then followed the usual order of detention until her Majesty's pleasure be known. Two of these thirteen were treated as dangerous lunatics under Section 15—the one that Dr. Urquhart referred to—in this way. One of them was a charge of culpable homicide, but not of a serious character. In fact it would have been difficult to have established any stronger charge than that of assault. The prisoner assaulted the victim, and it was not till ten or fourteen days afterwards that the victim died, and no very serious notice had been taken of the crime at the time. It was thought that it was only an ordinary case of assault, but owing to death having occurred, the case assumed a more serious character, and the man would have been indicted for serious assault or culpable homicide. The question of insanity was raised in his case, and upon my report the Crown determined to commit that man as a dangerous lunatic, and so advantage was taken of Section 15. The other case was one that was dealt with ten days ago, where a man, Joseph M'Queen, threatened to murder his wife, in connection with the Motherwell tragedy. His son had murdered an uncle in Motherwell, and the father, who suffered from alcoholic dementia, began to utter threats that he and his son would die on the same scaffold for a similar offence. He was dealt with as a dangerous lunatic. It was simply an expedient to get out of the difficulty of indicting him. In three cases the procedure was adopted which one is tempted to describe by the vulgarism of splitting the difference. The plea of insanity was set up, and, as I think, might have been established, or ought to have been established, but the difficulties being so considerable the Crown and the defence agreed mutually to take a middle course—the Crown accepting a plea of guilty of modified crime, and the prisoner taking a modified sentence. I cannot but say as the result of my experience that the judges are perfectly willing to accept of reasonable evidence of insanity without special regard to the questions referred to. Whatever English judges may say, my experience of Scottish judges is that they are very willing to view the case on its merits, if it be presented with reasonable fulness and accuracy to the Court.

* In some parts of Scotland this is a common practice.—[ED.]

I would just like to say, with regard to the lesser offences, that there is great room for something to be done in the direction of understanding the mental condition of juvenile and adolescent offenders, and I don't think it would be extravagant to suggest that in the case of first offenders, juvenile and adolescent, an inquiry should be held by specialists for the information of the prison officials. I think it would be a pity to put forward an opinion of insanity with regard to these before a judge or a sheriff, but on the facts of the case the sentence might be given, and the special way in which the prisoner might be dealt with afterwards could be committed to the Prison Commissioners, who have considerable powers, and who might be entrusted with greater powers. If it were pointed out that this prisoner was manifestly neurotic or insane, he might be dealt with in a special way, not necessarily by committal to an asylum.

Dr. M'PHERSON—It was not my intention to speak upon this question, but Dr. Carswell has referred to one or two cases in which I was interested. One of them raises a point which the Committee appointed to deal with this matter might have taken cognisance of. This man was a degenerate, as the term is used by continental writers, and had systematised delusions of persecution about his wife. He shot his wife, but fortunately she did not die, and he fired three shots into his own mouth, but did not succeed in taking away his own life. I received a letter asking me a question about premeditation, and I told the agent that premeditation was quite clear in this case, as it was in all cases of the kind. If the man had not bought the pistol, he had bought laudanum to take if his attempted suicide failed otherwise, and he had, according to his own statement, fervently prayed to the Supreme Being for strength to enable him to commit the act that he was going to do. The result was that the counsel dropped the plea of insanity, and the Crown accepted the minor degree of offence. The judge, in passing a sentence of eight years' penal servitude, said that if he believed that the man had bought the pistol for the act and premeditated the offence he would have given him a sentence of penal servitude for life. I think that raises a very important point indeed, because there is no question that all those patients labouring under persecution mania deliberately premeditate the deeds that they are going to commit. With regard to the other case that Dr. Carswell referred to, the man was an epileptic, and was known to take what were called hysterical attacks. Those in the Glasgow Prison attracted the notice of the Crown authorities. I could not trace the history of any of the fits except one, which was very indefinite, but he had the appearance of an epileptic. I reported that he was an epileptic, and was irresponsible for his actions. When I got to the Court-house I found—though I was cited by the Crown—that I was not to be called as a witness. The defence took up my evidence, and said they would examine me. The judge in summing up severely animadverted on my statements, and said that it was on all fours with the sort of medical evidence that was being trumped up to get people off who were guilty of such crimes. He gave them his definition of insanity, and left them to judge between his definition and mine. However, the jury were impressed by my evidence, and they brought in a verdict of "guilty," with a strong recommendation to mercy, on account of the state of the man's mind. Sentence of death was passed, and the recommendation having been forwarded to the proper quarter, Sir Arthur Mitchell and Dr. Yellowlees were appointed to examine him; and on their recommendation the sentence was commuted to penal servitude for life, but while on the way to Peterhead he committed suicide by hanging himself.

Dr. TURNBULL—I think we have wandered a little from the point of the report, whether or not there is any need for alteration in the law, and whether or not we concur in the conclusions of the Committee on that matter. I think we must all allow that they have presented us with a very suggestive and interesting report. It seems to me as if the report was something like the practice in cases of the criminal insane—it is a little illogical, but it reaches the best conclusion, though in an illogical way. For instance, in one part of the report they make out that the McNaghten questions can only be tolerated if a meaning was brought into them that they were never

meant to bear ; and in spite of that they think that the law calls for no change I think the McNaghten questions are dying a natural death ; and they are not adhered to in the cases that come before the Court. Perhaps our best plan is to let them die a natural death instead of making an onslaught on them as Dr Urquhart proposes. I think the cases that we have all a little doubt about are those which are upon the border-land, where it is debatable whether they are fully insane and irresponsible or not. These people are allowed to go about, yet the moment one of them commits a crime he claims the benefit of his peculiar mental state, and wishes to be held irresponsible. I don't know that that is quite right ; and it seems to me that the idea of limited responsibility is one that is properly applicable in these cases. There is much difficulty in saying what is the best way of determining that responsibility, and I think that if medical evidence was brought into Court and submitted to cross-examination, and put before the jury without appealing necessarily to the McNaghten questions, probably that would be a sufficient guarantee to the public that the cases were properly inquired into and properly dealt with.

Dr. RONALDSON—I have simply to say that my experience has been altogether in accord with that of Dr. Turnbull. In regard to those legal cases to which allusion has been made, I find that when the question arises, the Procurator-Fiscal asks my opinion as to the mental state of the prisoner ; and accepts my opinion and hands the case over to the parochial authorities, if it is a parochial case. The case is sent to the asylum under my care, and there are no further questions put. When the patient recovers I discharge him as a recovered patient. I have never had any difficulty in dealing with these cases.

The PRESIDENT—No doubt, as Dr. Turnbull has said, we have somewhat wandered from the question under discussion—the report of the Committee—but I do not think that any great harm has resulted from that, because we are talking, if not of the report, of certain collateral questions. My own feeling is that the discussion of capital cases and of minor offences cannot be carried out simultaneously, not that minor offences are dealt with in a perfect way, but because the treatment of the two does not run on parallel lines, and when I say that they should not be discussed together I have no wish to imply that minor offences should not be dealt with as minor offences, but that they should be dealt with apart from the graver questions of the fatal results that are associated with decisions in capital cases. Now of course I have had wide experience of the working of the law in England, and my belief is that no insane person is hanged. It is our own blame in England if that happens, for medical men and neighbours, and members of the community generally, are as capable of reporting to the Home Office and demanding an inquiry as those who are more immediately engaged in the trial. The Home Office is always ready to sift and look into the nature of evidence submitted to it, and to ascertain on these occasions if something more could be done. They ask the opinion of the judge if there are circumstances connected with the evidence which might be reconsidered, and then, after they collect this evidence, they send for someone. Medical men are sent down, and on their decision the Home Secretary refers to the judge again, and thoroughly sifts the matter in the light of the fresh evidence that has come before him. He leaves nothing undone, and I feel that the confidential reports of medical men are so thoroughly considered and laid before the judge, and that the whole matter is so dealt with that it is impossible for me to conceive a stronger or more complete inquiry before any man is sent to the scaffold. It has been my own experience, unfortunately, to differ in opinion from some medical men in those cases, sometimes finding the medical witnesses distinctly contradicting each other, and I have had to arrive at a conclusion which differed sometimes with the one side and sometimes with the other. Medical Superintendents have said that a man is sane and ought to be hanged, and I have had to find that there was distinct evidence of insanity before the fatal act occurred ; and I may say that a considerable difference exists in the capacity of medical men in sifting the criminal's mind. It seems to me in talking with other medical men and those from asylums, most eminent men in matters of insanity, I have been com-

pelled to come to the conclusion that in some cases they have not been able to turn out the soul of the individual at the time that he committed the act, and you have to do that before you are in a position to report completely and thoroughly to your own satisfaction. One man may be satisfied with one kind of conversation with the convict, and another man might require repeated conversations. The great difficulty is in laying down any general guide that will be applicable or much help to a medical man in worrying out the circumstances and motives of the individual in committing the act for which he has been tried, and with all humility I say that one has to carry it out in one's own way. I am unable to criticise or blame others because they have arrived at a conclusion different from mine. My own feeling is that it rests with us, and I think it is a great and important subject that the Association, at any rate, can always have before its mind—that of watching the progress of cases of this sort, and being ready to supply the knowledge that appears to have been left out, and to write to the Home Office or the local authorities. I think the discussion of to-day is worthy of the occasion. I am sure that it will merit future consideration, and I hope that it may lead to useful results.

INSTRUCTIONS TO COMMITTEE ON PENSIONS SCHEME.

Dr. URQUHART briefly related what had been done in this matter, and reported that the Committee had called upon Mr. J. A. Robertson, C.A., to make a preliminary statement for consideration. This would enable them to make a report to the next meeting.

Dr. TURNBULL—The recommendation of the Annual Meeting was that the sum to be expended be not more than ten guineas, and that that sum, or any part of it, be payable to any properly-appointed Committee, and I beg to move that the Committee be reappointed with these powers, and with instructions not to exceed the expenditure of ten guineas.

Dr. J. CARLYLE JOHNSTONE—I beg to second that.

The motion was put to the meeting and unanimously agreed to.

ROXBURGH DISTRICT ASYLUM.

Dr. CARLYLE JOHNSTONE showed the plans of the new female infirmary which is to be erected at the Roxburgh District Asylum, and explained the internal arrangements of the building.

COLLECTIVE INVESTIGATION.

Dr. G. M. ROBERTSON—At the last meeting of this Division a Committee was appointed to consider this question of collective investigation; and at that meeting it was unanimously agreed that this was a subject that was well worthy of our attention; and it was also thought that the Association had not given it that attention in the past that it should have done. The Committee consists of Dr. Urquhart, Dr. Turnbull, Dr. Carswell, Dr. Mitchell, and myself. We have discussed the question, and the report is in your hands. I suppose it is not necessary for me to go over it. My attention was directed to this question of collective investigation by the fact that many members of the Association were constantly sending round asking questions about different things in asylum administration, which were answered, perhaps, at the cost of some trouble, and then we heard nothing more about them. I thought that instead of going on in this irregular manner, our methods should be more systematised. Since the Committee has been appointed there have been two collective investigations of a private kind. Dr. Watson, of the Govan Asylum, issued a series of questions, and I wrote to him asking him to summarise and tabulate his results for the gentlemen who answered his questions with regard to having a matron or a housekeeper in an asylum. He did this, and sent round his summaries, which were very interesting. The Greenock Asylum also issued a series of inquiries as to the number of attendants compared to patients, and I wrote to the secretary there asking him to tabulate the results of the inquiries, which he has done. In discussing this matter with the members of the Committee the recommendations we came to were the following: "That members should be asked at the meetings of the Division, to propose desirable subjects for investigation, these being medical, psychological, administrative, etc." "That the subject or subjects

suggested should be printed on the billet of the next meeting for objection, modification, selection, or approval." Seeing that a good deal of trouble would be caused to members in investigating these questions, it was but right that they should have a chance of objecting to any questions and preventing the views of any particular man being forced. This gives the seal of authority. "That, if the wish of the meeting be that a certain line or lines of inquiry be adopted, authority should be given to one or more members (according to the number of subjects) to act as secretaries, to issue questions, to render uniform, so far as is possible, the methods of inquiry adopted, to receive the answers, and to tabulate and summarise the results." "That the member suggesting the subject adopted be asked to act as secretary for that subject, and failing him, any other; it being recommended by this method to decentralise and to diffuse among all the members interest in these inquiries." If the Association approve of that subject then it grants power to the member to carry out his investigation, to ask other members of the Association to take the trouble to answer his questions. It was thought much better that, instead of appointing one secretary to do all this work, any person could be the secretary for the special subject that he took an interest in, and in that way each man would take a keener interest than a general secretary. It also diffused interest in the members of the Association instead of having a small clique who would go on collecting information. The next recommendation is "That the tabulated and summarised results be laid before the next meeting, if possible." "That it is to be hoped that all members will assist, so far as is possible, to carry out these investigations in their asylums, it being understood that any undesirable subject may be objected to at the meeting, and that all inquiries entered upon have the recommendation of the Division." As to the investigations that have been carried on by private individuals, one can understand that members may object to carry out a series of investigations for the sake of a private member, but if the inquiry is authorised by the whole meeting it shows that the subject is worthy trouble should be taken to further the interests of the Association. The seventh head was suggested by Dr. Urquhart:—"That a small standing Committee be appointed to keep the question of collective investigation before the Division, a member of which should be the Secretary of the Division, to bring inquiries adopted into touch and uniformity with the rest of the Association, if necessity for this should arise." I understand that other divisions are going to take up the subject, and it is desirable that we should be kept in touch with the other divisions, and by appointing a small standing Committee, and also by appointing the Secretary of the Division one of the members, all the different divisions could be kept in touch, and the scope of any inquiry that was gone into could be carried out and extended in other divisions.

The PRESIDENT—I have great pleasure in proposing that this report be adopted, and that steps be taken without delay to carry out the provisions and recommendations which are embodied therein, with the view of getting to work at once on so desirable and hopeful a scheme. I am quite sure that it goes without saying that there is plenty of work to be done, and that with willing workers it is a great pity that means should not be taken for bringing that work into a focus, and thereby benefiting the general objects of the Association. I think we are doing something of the sort in London. Dr. Mercier had something before a recent meeting, so that you are a bit ahead of us, but we are always willing to take a lead from this side of the Tweed. I am sure that excellent results will be obtained if the recommendations are carried out.

Dr. IRELAND—I have no objection to this report of my friend Dr. Robertson being adopted, but at the same time I think we should clearly understand what it amounts to. I may say that the proposal to form a Committee in order to investigate particular subjects has been generally adopted since ever I remember this Association. Any member who had some particular inquiry which he considered of sufficient importance to bring before the Association stated it, and gave notice on the billet of reading a paper on the subject, and generally a Committee was formed and information was collected. Of course it has been determined by precedent that we have full power to do this. I remember at the

meeting in Carlisle, I myself read a paper about the detention of idiotic children in asylums, and a Committee was formed. We made inquiries and ascertained the number of such children as were detained in asylums for adults. The principal novelty, I suppose, which Dr. Robertson has in his motion is, as it were, that we should be pushed on to provide this kind of machinery by which our lagging spirit of inquiry should be goaded into more energetic action. I have no objection, but I would not like to have different people prevented from asking about some particular subject. I don't think he meant it, but he implied that that had become or might become a nuisance, and that his better regulated scheme would supersede this. It has been a custom in this Association for men well-informed in science and in special branches to be asked for information, and to give it to other gentlemen who were making inquiries in the same field, and I have often received very useful information in a very courteous manner from different persons. I certainly would not like that practice to be discontinued.

The PRESIDENT—I think the intention is to strengthen the hands of those individuals and not to supersede them.

Dr. IRELAND—But he means to give an official sanction. Perhaps some inquiry might not be accepted by a majority of the Association, and then, as it were, he might be shut out in the cold as a troublesome individual. However, that is merely a possibility. I have often been dissatisfied with small Committees. The general rule is for the gentleman who has made his proposal to nominate his Committee, and then other members are much too modest to propose themselves, and even, although they are anxious to get a kind friend to propose them, they do not dare. I should say that they should be appointed in a regular manner, and that they should be elected by ballot or vote. Otherwise I have no objection to Dr. Robertson's proposal, and I second the motion made by the President.

On being put to the meeting, the motion was unanimously agreed to.

Dr. TURNBULL—I beg to move that Dr. G. M. Robertson, Dr. Oswald, and myself, *ex-officio* as Secretary for the branch, should be put on the Committee.

Dr. URQUHART—I second that motion. Dr. Robertson has taken up this important work and we should give him every possible aid. We do not want to trench on the ground lying untilled in England. Dr. Mercier brought up this subject in London last May, and requested those willing to help to give in their names. Some of us responded at once, and we shall no doubt soon hear the result; but this is a Divisional Committee for Scotland. We desire to keep in touch with London, and not to enter on any scheme of collective investigation that could not be accepted there. I hope that a Committee will be formed at headquarters to bring all these investigations to a focus. We wish to work with the other Divisions and with the general body of the Association; but, at the same time, we wish not to be hindered in our operations or to wait any longer than we have done.

Dr. CARLYLE JOHNSTONE—I quite sympathise with what Dr. Ireland has said, but I think that before proceeding to vote we should have some light thrown on the subject by those who personally know members whom they consider to be suitable. I would like to state my own opinion, and I think that the Secretary himself should be a member of the Committee, and that Dr. Robertson ought to be on it, seeing he has had the work to do—I am going to vote for him—and I cannot think of any one better than Dr. Oswald, who represents a different district of the country and a different school. Committees are often appointed in a very arbitrary manner and perform their duties in a very perfunctory manner, but Dr. Turnbull's proposal seems to be eminently reasonable.

Dr. IRELAND—I should judge that Dr. Robertson is sure to be elected. That leaves us to elect one, and I think we should have a Committee of five. I am not at all urgent in the matter, but I think that it is possible that the number should be made five.

Dr. CARLYLE JOHNSTONE—I move that it be three, including the Secretary of the Branch.

Dr. MIDDLEMASS—I beg to second that.

On being put to the meeting, Dr. Johnstone's motion was agreed to.

Each member present wrote on a slip of paper the name of the gentlemen whom he wished on the Committee, and after the scrutineers had handed in their report,

The PRESIDENT said—There is practically a unanimous vote for Dr. Robertson and Dr. Oswald. Dr. Robertson and Dr. Oswald, along with the Honorary Secretary, will, therefore, form the Committee.

Dr. WATSON, on behalf of those present, begged to thank the President for his interest in the work of the Branch, and for his presence on that occasion.

Dr. NICOLSON suitably replied, and the proceedings terminated.

The usual dinner then took place at the Palace Hotel.

MEETING OF THE SOUTH WESTERN DIVISION.

A meeting of the South Western Division was held at Wonford House, Exeter, on Tuesday, 15th October, 1895. There were present Dr. P. Maury Deas (who was voted to the chair), Drs. Morton, Aldridge, Weatherly, Felvus, Mortimer, Wilson, Davis, Wade, Benham, Aveline, and Macdonald (Hon. Sec.)

Dr. DEAS, in welcoming the members, said this was the first meeting of the Association ever held in Exeter, and he could only wish that there had been a larger attendance and that it had been a finer day. He felt it a privilege to do what little he could to make the gathering a pleasant one.

The minutes of the previous meeting were then read and confirmed.

LETTER FROM MRS. HACK TUKE.

The HONORARY SECRETARY read a letter from Mrs. Hack Tuke thanking the Division for their vote of sympathy and condolence.

ELECTION OF NEW MEMBERS.

The CHAIRMAN declared that the following new members had been duly elected :—

ROBERT LEONARD RUTHERFORD, M.D., Medical Superintendent, Digby's Asylum, Exeter.

WILLIAM BRITAIN MORTON, M.B., Assistant Medical Officer, Wonford House, Exeter.

ALLAN MACLEAN, M.D., J.P., St. Martin's, Weymouth.

MAURICE HOWARD LASLETT, L.R.C.P., Assistant Medical Officer, Somerset and Bath Asylum, Wells.

THE NEXT PLACE OF MEETING.

A discussion took place with regard to the next place of meeting, in the course of which Dr. MACDONALD suggested that as far as possible the meetings should be held in the centre of the district. This found general acceptance. It was eventually decided to hold the next meeting on Tuesday, 14th April, 1896, at Gloucester.

REPORT OF THE COMMITTEE ON CRIMINAL RESPONSIBILITY.

The CHAIRMAN said the Hon. Secretary had a report to make with regard to a communication from the General Secretary.

Dr. MACDONALD stated that he had received a copy of the report of the Committee on Criminal Responsibility, and also a letter from the General Secretary asking him to bring the report before the Divisional Meeting. As this report came the day after the notice for this meeting went out, he of course could not bring it forward that day, and perhaps it was better that he could not do so. He asked for instructions.

Dr. WEATHERLY emphasised the views he expressed at the discussion upon the report at the last Annual Meeting of the Association (*vide* No. for Oct., 1895, p. 744), and referred to the resolution put from the chair on that occasion, and unanimously adopted. He earnestly hoped that, when this matter came up for discussion at their next meeting, they would be able to send up such

a resolution to the Annual Meeting that this report would be put on the shelf for ever and a day.

The CHAIRMAN—Is there any resolution on the subject The Secretary asks for instructions.

Dr. MACDONALD—I don't think we shall differ very much from what Dr. Weatherly has said. My idea is that this report should be the first item on the agenda at our next meeting, and that we then discuss it. I move that this course be adopted.

Dr. WEATHERLY having seconded, the CHAIRMAN then put it to the meeting that the consideration of the report on criminal responsibility be placed first on the agenda for the next meeting, and this was agreed to *nem. con.*

PAPERS READ.

Dr. DEAS opened a discussion on mechanical restraint. (See page 102).

Owing to the limited time at the disposal of the members the Honorary Secretary's paper on the "Nursing Staff" was, with regret, again held over until the next meeting.

Dr. MORTON read notes on "Three Cases of Spontaneous Gangrene. (See page 119).

Dr. WADE said the very pleasing duty fell to him of proposing a resolution which, he was quite sure, would be carried by acclamation, namely a very hearty vote of thanks to Dr. Deas for his kind reception of them at Exeter. He was only sorry that, Exeter being at one end of the district, they had not had a better attendance; yet, indeed, he did not know that Exeter being at one end of the district had anything to do with it, because there were several members within a stone's throw who had not attended. He was afraid that with asylum life some of them got very fond of staying at home. That was a bad plan, and was a poor return for the hospitality shown them, and for the trouble their Honorary Secretary took to get the meetings together.

Dr. BENHAM had very great pleasure in seconding, and the motion was carried by acclamation.

Dr. DEAS suitably replied, and the meeting terminated.

The members afterwards dined together at the New London Hotel.

MEETING OF THE IRISH DIVISION.

A meeting of the Irish Division was held at the District Asylum, Limerick, on Wednesday, the 23rd October, 1895.

The following members were among those present:—Dr. Bagenal Harvey (Clonmel), Dr. Nash (Limerick), Dr. C. Norman (Dublin), Dr. O'Mara (Limerick), Dr. O'Neill (Limerick), and Dr. Oscar T. Woods (Cork), Honorary Secretary. Drs. Gelston and Shanahan, of Limerick, were present as guests.

On the motion of Dr. O'NEILL, Dr. Conolly Norman took the chair.

ELECTION OF NEW MEMBERS.

The following gentlemen were duly proposed for election as members of the Association, and having been balloted for, were unanimously elected:—

JAMES CASHMAN, M.B., B.Ch., B.A.O., R.U.I., 3rd A.M.O., Cork District Asylum.

JOHN FRANCIS SHANAHAN, L.R.C.P.I., L.R.C.S.I., 2, The Crescent, Limerick, Medical Officer of the Limerick Workhouse.

DR. O'NEILL'S PAPER.

Dr. O'NEILL read a paper on "The Systematic Employment of the Insane," which, together with the discussion, will be published in a future number of this Journal.

DR. O'MARA'S PAPER.

Dr. O'MARA read a paper on "Artificial Feeding." He was of opinion that artificial feeding should be resorted to when a patient remains 36 hours without

food, if not after 24 hours. He reviewed the different methods of feeding, and adduced reasons in favour of oral as opposed to nasal feeding. He preferred to have the patient in a sitting position, believing that the risk of injury to the patient from struggling was greater in the recumbent position, owing to the position of the attendants controlling him.

The paper gave rise to a lively discussion, on somewhat similar lines to those taken by the various speakers to a paper read on the same subject at the last Annual Meeting in London.

Dr. Woods dwelt upon the indications for artificial feeding, dividing the patients who refused food into three classes—the dyspeptic, the delusional, and the melancholic (including suicidal). The indications differed in each case, and all three might be very troublesome. The dyspeptic were often markedly benefited by washing out the stomach. Sometimes one meets with cases in which food is refused by hysterical young women, or out of mere perversity by patients who wish to give trouble. Neither of these classes are very determined, and they can often bear a little judicious neglect.

Dr. BAGENAL HARVEY differed from the reader of the paper in preferring the nasal to the oral method. He regarded the nasal method as quite free from danger, especially if one used a soft tube. By the simple device of pinching the soft tube one could be always sure whether one had put it into the larynx or not.

Dr. O'NEILL expressed a personal preference for the nasal tube.

Dr. NASH, when he was Assistant Medical Officer at the Dublin Asylum, generally used the nasal tube, and preferred it. Sometimes it presented special difficulties, and sometimes with obstinate cases he used the œsophageal tube, because he was satisfied it was much less agreeable. His chief's opinion used to be that there was less disposition among the patients in this country than those in English asylums to refuse food, but as the speaker had often as many as ten patients to feed of a morning he was quite satisfied with his proportion. It had been objected to the nasal tube that it was slow, but Dr. Nash thought this was a good fault, as it was very injurious to feed a feeble patient too quickly.

The CHAIRMAN described Hayes Newington's apparatus for nasal feeding, which he at one time used exclusively. He agreed with Dr. Harvey as to the ease with which you could discover if you went the wrong way. He had thus satisfied himself on one occasion that he had put the nasal tube into the trachea, but as he had not begun to feed no harm was done. The danger of prolonged artificial feeding arose from the monotony of diet and its general want of fresh vegetables. It was dangerous to trust too much to farinaceous food. He was in the habit in protracted cases of rubbing down potatoes into a thin mash, also of cutting finely and pounding up onions and other strongly flavoured vegetables.

Dr. O'MARA admired the courage of Dr. Norman in adhering to the nasal tube in spite of the experience he had narrated. Dr. O'Mara still was disposed to prefer the œsophageal tube, but would confess that it appeared to be to a large degree a question of individual tact and of personal preposition, perhaps derived largely from chance first impressions.

CRIMINAL RESPONSIBILITY.

Dr. OSCAR WOODS, Divisional Secretary, brought before the meeting the report of the Committee on Criminal Responsibility, which the Association in General Annual Meeting had desired should be brought before each Division for an expression of opinion.

Dr. Woods argued that the present state of the law was unsatisfactory and perhaps dangerous. The questions put to the judges by the House of Lords were too narrow, and the power of the judges to issue a dictum on the subject was questionable as a point of constitutional law. It was perfectly preposterous to say that the question of a man's responsibility, on which depended his life or death, should be decided by his knowledge of the difference between right and wrong. This was the test at present, at least according to some of the judges. Things were little better if the whole question turned on some ridiculous quibble as to the meaning and force of the word "know."

The CHAIRMAN agreed with Dr. Woods in the main. The real crux for them

was to know what they were to suggest in place of the present condition of affairs. The supposed existing legal test was essentially illogical, and was, as they all knew, quite indefensible from a practical point of view, but if they wished to substitute something else they would be called upon to prove first that the present system actually operated unfairly, and secondly that they had something better to put in its place. There are difficulties in both respects. The lawyers have their crotchets, but the public seldom allow any substantial wrong to be done. The law in its stupid way insists on definitions. Our contention should be that we cannot and will not define what we believe to be indefinable. If we enter on definition the lawyers will always beat us in hair-splitting, and even if we succeeded for the time we would do harm, for the progress of opinion and the advance of knowledge will surely leave our definitions behind, and we will injure instead of serving science and humanity. We should always remember that we are not in the position of lawyers, who too often in this discussion allow themselves to be carried away by a desire for a forensic—a verbal—triumph, and who are too apt to treat with an arrogance which is born of professional jealousy those who trespass upon what they consider their preserves. Looking at the question from a professional point of view, we can afford to wait. When precedent, the law, and the House of Lords are on one side, as we are often told, and the doctors and educated public opinion are on the other, we know which will win. The Bar and the Bench may pull any amount of feathers out of us in the witness-box, but when we have facts at our back our opinion is generally the last one heard, and is the one which really decides the issue. We should be very careful, therefore, in going any further than declaring our conviction that the test of responsibility founded on the knowledge of right and wrong is insufficient, and out of conformity with the present state of knowledge.

Dr. O'NEILL said that the Division was to be congratulated on the action of Dr. Woods in connection with this matter. The subject of the criminal responsibility of the insane was one which had long occupied the attention of asylum physicians, and had been from time to time a bone of contention between the faculty and the law, but it was due to their Secretary to say that his paper, read at the Dublin Meeting last year, had brought the subject forward with a prominence which it never had had before, save on the rare occasions when a case like that of McNaghten attracted universal attention. To the vigour and persistence of Dr. Woods, and to the ability with which he put forward what might be called the medical view of this question, is owing the general interest that the topic has excited throughout the whole kingdom for the last sixteen or seventeen months. Many able utterances have been made, and much light has been thrown on the whole question. The labours of the Association's Committee, it may be hoped, will also aid in bringing this long-vexed question nearer to a solution. He was of opinion that they should not break up that day without adopting a resolution indicating their opinion as to how the present unsatisfactory condition of things could be amended.

Dr. NASH said that one point had not been touched on, which was of much importance. The procedure was surely faulty by which the Crown does its best, or appears to do its best, in criminal cases to have a lunatic found guilty and executed. Surely every fact that can be ascertained, which throws light upon the prisoner's mental condition, should be placed before the jury with the utmost impartiality. It is true that in any capital trial a man's life is at stake, but in other cases the greater the probability of a man's guilt the better he will be able to fight for himself. This is not so with the insane, and the Crown should be as anxious as the prisoner's own counsel to produce every fact, and have the man's mental state thoroughly investigated. The matter becomes worse when the judge, whether influenced by distaste for medical dictation, as Dr. Norman hints, or not, puts before the jury the narrowest possible view of the law, and refuses to the lunatic that benefit of the doubt which is given to every other prisoner.

After a prolonged discussion, in which Drs. O'MARA, HARVEY, GELSTON, and SHANAHAN took part, the following resolution was proposed by the SECRETARY, seconded by Dr. O'NEILL, and adopted:—"That while the Irish Division

of the Medico-Psychological Association is not prepared to recommend that there should be any alteration in the law defining criminal responsibility, it is of opinion that the procedure now frequently adopted in England and Scotland of having all criminals, about whom there is the least suspicion of insanity, thoroughly examined by medical experts before their trial, and as soon as possible after the commission of the crime, should be universally adopted, and the evidence thus obtained laid before the jury, whether for or against the prisoner. It is also our opinion that more latitude should be given to medical witnesses to explain fully their exact view of the mental condition of the prisoner, subject, of course, to the closest cross-examination."

Owing to the advanced hour a paper promised by Dr. Conolly Norman was postponed, and the proceedings terminated with a warm vote of thanks to Dr. O'Neill for having invited the Division to meet at the Limerick Asylum.

BRITISH MEDICAL ASSOCIATION.

We have now placed before our readers the greater part of the proceedings of the Section of Psychology at the last Annual Meeting of the British Medical Association, and here append an abstract of Dr. Gowers' paper on

THE RELATIONS OF EPILEPSY AND INSANITY.

Dr. GOWERS, in opening the discussion, restricted himself to the consideration of idiopathic forms and the clinical aspect.

The first striking relation of insanity and epilepsy, he pointed out, was their family interchangeability, and he dwelt on the need for statistics as to the proportional relations of epilepsy to insanity generally, and to its different forms; its relation to an associated history of insanity, and also of inquiring if any relation existed between epilepsy as a family antecedent and the course of the forms of insanity in which it occurs.

Dr. Gowers had ascertained the heredity of insanity with epilepsy in 50, and of insanity only in 37 per cent. of his epileptic cases, but regarded these estimates as untrustworthy from the popular tendency to refuse to acknowledge hereditary diseases of this class.

The consideration of the associated diseased conditions he held required careful limitation, especially by the exclusion of cases of simple mental failure or arrested brain development from epilepsy.

Post-epileptic mania, he thought, should be kept distinct as an "entirely separate form." While accepting Dr. Jackson's explanation that this state results from the unrestrained activity of lower centres, he did not regard this as the whole truth, since he had met with cases with unrecognisable precedent epileptic phenomena. He anticipated that study from the insanity aspect would confirm Jackson's theory that "the slighter the discharge, *i.e.*, the more extensive the function undischarged, the more manifest and elaborate is the post-epileptic automatic action."

A predisposition of the lower centres to pass into a state of morbid activity was inferred from the hysteroid symptoms which follow epileptic attacks, and justified by the fact that these occur in women almost exclusively in the first half, and in men in the first third of life; moreover, that psychical disturbance, often associated with a special sense centre, at times commences a fit. From this last fact he argued that the elaborate mental process which sometimes commences an epileptic discharge might solely constitute it, and that thus brief insanity might be truly epileptic, and not post-epileptic.

The occurrence of insanity in the course of epilepsy and the forms it assumes he urged needed further study, and also the precise features of the attacks in epileptics who undergo attacks of insanity. These last, he believed, especially occurred in patients in whom epileptic attacks were preceded by psychical or psycho-sensory auræ.

In the discussion Dr. HYSLOP said that from Dr. Hughlings-Jackson's scheme of

evolution and dissolution it was difficult to understand the nature of the positive psychical symptoms in epilepsy. We can, he said, readily conceive that brain disturbances may determine losses of local memory, and this would correspond to the negative lesions of Hughlings-Jackson, but the mere existence of a negative lesion does not in the least explain the nature or origin of the positive morbid symptoms which are thought to be due to evolution going on in the undamaged remainder. When we confine ourselves more particularly to the consideration of the negative lesions and their effects, we find that we have to deal with disorders of memory, and, synonymously, therefore, with the comparing faculty. From a clinical point of view, however, we cannot reconcile or adopt the possible existence of a negative brain lesion with the mental symptoms of the insane. In epileptic states of the slighter variety we can readily conceive that local brain disturbances may give rise to temporary or local amnesias, but we do not in the least understand the methods whereby the positive psychical symptoms come to have their origin and abnormal character.

Professor BENEDIKT said that he saw many cases which were not recognised as epilepsy, but rather as a vice or passion, as in a man who had a fit whenever he took alcohol.

Dr. CONOLLY NORMAN expressed his surprise that Dr. Gowers had not seen cases of post-epileptic mania in women, of which he had seen several.

Several other gentlemen also took part in the discussion, which terminated by appointing a small Committee to consider the subject and submit proposals to the Council of the Association.

ABNORMAL FORMS AND ARRANGEMENT OF BRAIN CONVOLUTIONS, BY DR. MICKLE.

This paper, which formed the Presidential Address, will be published in succeeding numbers of this Journal, along with other important matter, which summarises much of the author's experience in pathology.

MEDICO-LEGAL CASES.

REPORTED BY DR. MERCIER.

[The Editors request that Members will oblige by sending full newspaper reports of all cases of interest as published by the local press at the time of the Assizes.]

Reg. v. Coombes.—"The Plaistow Murder."

Robert Allen Coombes, 13, was indicted for the wilful murder of his mother. The facts, which were not disputed, were of a very revolting character. The prisoner and his younger brother, Nathaniel, æt. 12, had for some days discussed the murder of their mother, who appears to have treated the boys not unkindly. On July 4th prisoner purchased a knife and concealed it. Early on the morning of the 8th he stabbed his mother twice with it while she was in bed. He had slept with his mother, and said that she had punched him during the night. He took money from his mother's purse, and accounted for his possession of it and for her disappearance by a series of ingenious and elaborate lies. He wrote a letter to the cashier of the company in whose employment his father was, asking for money on the ground of his mother's illness, and backed up the application with an old medical certificate, from which he tore the date. He wrote another letter to his father, in which he accounted for his mother not writing by saying she had hurt her hand. He also wrote an advertisement for an evening paper, asking for a loan of £30. The two boys agreed that the elder should stab their mother when the younger gave a signal by coughing twice. On the morning of the murder and after the crime they went together to Lord's Cricket Ground.

Evidence was given that the boy was a very clever boy for his age, and was a very good boy at school, and that he was very fond of reading sensational books, and took great interest in the trial of criminals.

The jury found a verdict of "Guilty, but insane."—Central Criminal Court,

September 15 and 16, 1895 (Mr. Justice Kennedy).—"Times," September 16 and 17.

The lay press was unanimous in declaring that a criminal of such tender years could in no case have been hanged; and in approving the verdict of the jury as a proper one for securing the safe custody of the prisoner without depriving him of life. Most of the more influential papers agreed that the convict really was insane. "The Times" admitted with regret that the verdict was the best that could have been given, but evidently did not accept the hypothesis of insanity.

In connection with the above case a long and unsatisfactory correspondence has taken place in the newspapers upon the influence of the "penny dreadful," to which responsibility for the murder was attributed by some writers. It seems obvious that while stories full of bloodshed and horrors might help to confirm and encourage, and even to give direction to, a tendency already existing, they cannot be considered responsible for the origination of such a tendency.

The case is further remarkable for the admission that it drew from "The Times" that the famous answers of the judges are, even if binding, "admitted to be infelicitous in language and by no means exhaustive," and for the suggestion in the same paper that "the Home Secretary might do well, from time to time in such cases as those of Coombes and Fox, illustrating the illogical character of the English law, to institute a departmental inquiry, in which the assistance of lawyers and doctors should be given." When "The Times" admits that the law on this subject is "illogical" and is capable of improvement, the position of the question is indeed advanced.

"The Lanchester Case."

This is the *cause célèbre* of the quarter. Miss Lanchester is a New Woman. She is a highly educated young lady, of prepossessing appearance, who adopted Socialist doctrines, and proposed to carry her principles into practice by cohabiting with a young artisan without being married to him. In this extremity her parents consulted Dr. Blandford, who, after hearing the family history and a full account of the past career of Miss Lanchester, had an interview with the lady and made a certificate of insanity with respect to her. An urgency order was made by her father, and she was carried off by force from the lodgings in which she was living, and admitted on Friday, October 25th, into the Priory, Roehampton. On the following Monday a second certificate was made by Dr. Finny, the family medical attendant, but before the petition for a reception order could be presented to a magistrate, the patient was visited by two Commissioners in Lunacy, who decided that she should be set at liberty.

The case excited an immense amount of interest throughout the country, and the comments in the daily papers were of the heated and sensational character that may be easily imagined—the "liberty of the subject," the "horrors of the madhouse," the "infamous lunacy laws," being the texts of their discourses. On the other hand, there was much sympathy expressed with the unhappy parents of the lady, and not a few of the letters expressed or implied the opinion, that whether Miss Lanchester was sane or insane, a young lady who held such perverse opinions, and insisted upon putting them into practice, was not hardly treated in being put in a lunatic asylum. With these opinions it is not the province of this Journal to deal, but there are features in the case which are of great interest to alienists, both on the scientific and on the practical aspects. These features are to be found mainly in the action of Dr. Blandford and in the action of the Commissioners.

Dr. Blandford was visited by the parents of the lady and was by them made acquainted with the facts: that their daughter, a lady born and bred, highly educated, twenty-four years of age, enthusiastic and indiscreet, was about to enter into relations of concubinage with a man of the artisan class; that she had always been eccentric; that her grandmother and her uncle had been insane. Dr. Blandford then visited Miss Lanchester and heard from her own lips a confirmation of the statement that she intended to live with the man as his concubine. She declared that she preferred concubinage to marriage, because marriage was

immoral; but how or why marriage was immoral, she did not, upon being asked, explain.

We have not seen the actual terms of Dr. Blandford's certificate, but these were the facts included in it. The question which has been much discussed, and generally answered in the negative, is: Are these facts sufficient to justify the opinion that the patient is of unsound mind and a proper person to be detained under care and treatment? Before considering this question, it is well to point out that, although, according to the form prescribed by the Act, the certifier states that he has "formed this opinion upon the following grounds," yet it is scarcely ever possible to state in the certificate all the "facts indicating insanity" which the certifier has "observed at the time of examination." When a witness is testifying to a jury, they judge of his evidence, not only by the actual words that he utters, but by his manner, his demeanour, his gestures, his play of expression—by a score of circumstances which it would be quite impossible to put down in writing, and of many of which the juror himself is scarcely aware. The same is the case to a far greater extent with the patient who is being examined with regard to his sanity. The facts put down in the certificate are those facts only which are capable of clear description. The certifier's judgment is often—it may be consciously or it may be unconsciously—based more upon grounds which he is either unable to state with sufficient force and precision to carry conviction or even meaning to a third party, or which influence his decision to an extent of which he himself is unaware. Such indications of insanity are not one whit less trustworthy for being difficult to describe.

There is another factor in the case which should not be overlooked. Miss Lanchester is said to have been "eccentric." What was the nature and what the degree of the eccentricity we are not told; but we may be sure that Dr. Blandford was told, and it is not unlikely that it had a material influence in forming his opinion.

For these reasons we do not regard the statement of facts contained in the certificate of Dr. Blandford as necessarily containing the whole of the facts upon which his judgment was based. Taking those facts only which are there set forth, viz., that a young girl of good birth, breeding, and education, has announced her intention of living as concubine with a "working man," and has declared that marriage was immoral, but could not say why, we are of opinion that these facts are sufficient to raise a doubt as to the sanity of the lady—that the case is one for investigation. It may be that the doubt could be dispelled—but it is a case for further inquiry. In this case inquiry was made. The family and personal history of the patient were investigated, and, on a personal interview, Dr. Blandford came to the conclusion that the patient was of unsound mind.

It has been stated that Miss Lanchester was considered insane because she held Socialist opinions, and a great deal of ridicule and rhetoric has been expended upon this supposed fact. But it is manifest to everyone who is not blinded by prejudice that the foundation of the certificate was not any *opinion* that she held, but her intention to adopt a certain line of *conduct*.

So far the conclusion at which we arrive is that the case was one which could only be decided by personal examination of the patient, in conjunction with a full consideration of her personal and family history. Taken alone, the facts set forth in the certificate are not inconsistent with either sanity or insanity. The case is a difficult one, and no one who is not in possession of all the data can give a trustworthy opinion.

We now arrive at the next stage of the case. The removal of the lady from her lodgings created a great outcry. The patient having been taken to the Priory on Friday, the Commissioners visited her on Monday, and after an interview of about an hour's duration directed that she should be liberated on or before the day on which the urgency order would expire. It does not appear that they were under any statutory obligation thus to prolong the time before which the patient need not be discharged. The statute (Section 39, Sub-Section 9) empowers them, if they determine that a patient ought to be discharged, to order his discharge, and fixes no limit as to time.

On the morning of the day in the afternoon of which Miss Lanchester was visited by the Commissioners, she had been visited by the medical attendant of the Lanchester family, who had made a certificate that she was of unsound mind. There are, therefore, two medical opinions that the patient was insane, but of the second the Commissioners were not aware.

With respect to the action of the Commissioners it will be observed that they were not in possession of all the data that guided Dr. Blandford in coming to a decision. They had the certificate, and they personally examined the patient, but they were presumably in ignorance of the patient's previous history. We have on the one side the opinion of two Commissioners, on the other that of Dr. Blandford and Dr. Finny. We may pair off Dr. Finny with one Commissioner. The Commissioner has the greater experience, but Dr. Finny had the more intimate knowledge of the circumstances. In comparison with the other Commissioner Dr. Blandford had not less experience, and fuller information. The evidence on the two sides must be regarded as equal, and the fact that the lady is a Socialist does not in our opinion necessarily imply that the question under discussion must be answered in the negative.

After her liberation, counsel's opinion was taken as to the feasibility of taking proceedings against the persons concerned in her removal to the Priory, and the following is published as the text of the opinion given by Mr. H. H. Asquith, Q.C., M.P., and Mr. Corrie Grant: (1) We are of opinion that Miss Lanchester cannot bring an action for false imprisonment against her father or her brothers, or against Dr. Blandford, with any reasonable prospect of success. Persons who put the machinery of the Lunacy Law in motion are protected against any civil or criminal proceedings if they act in good faith and with reasonable care (53 and 54 Victoria, c. 5, Section 30). In the case of the relatives there is no evidence of want of good faith, while the fact that they consulted a specialist in mental diseases, such as Dr. Blandford is known to be, is direct proof that they did act with reasonable care. In the case of Dr. Blandford, his certificate itself, frankly setting forth facts which are not irreconcilable with sanity, is some evidence of good faith; his inquiries elicited the facts to which he certifies, and those facts are admittedly true. It may be that he was wrong in his deductions from those facts. If so, he committed an error of judgment, but an error of judgment is not actionable unless it proceeds from a want of reasonable care and skill, of which we see no sufficient evidence. (2) In an action for libel against Dr. Blandford, Miss Lanchester would have to prove that the certificate, which is clearly a privileged document, was false in fact—an allegation in which she would fail. (3) Proceedings by Mrs. Gray against Henry Vaughan Lanchester for assault would not raise the question of the legality of Miss Lanchester's seizure and detention. To such proceedings he would answer successfully that he was acting under the authority of the urgency order, that Mrs. Gray interfered to prevent the removal of his sister, and that he used no more force than was necessary to carry out this purpose.

As may be imagined, when the Lanchester case was reported in the papers they began to furiously rage together, and indulged in wild vaticinations against "private asylums," as if the particular class of the institution to which Miss Lanchester was sent had anything whatever to do with the law or procedure under which she was sent. Among the papers most forward to imagine a vain thing, "Truth" made itself conspicuous. The arguments of this paper are, it must be admitted, unanswerable. The chief one consists in dropping Dr. Blandford's title, and styling him "one Blandford," or, *simpliciter*, "Blandford." This argument is, as we have already admitted, unanswerable, and, when it is brought forward, we feel that there is no defence, and that private asylums, the Lunacy Laws, and "mad doctors" must all prepare to be forthwith swept off the face of the earth.

In striking contrast with the comments of the lay press upon the case of Miss Lanchester are the animadversions upon the Lunacy Law, and upon those who have to administer it, made in connection with a series of cases in which assaults have been committed by lunatics, some of whom have been discharged from asylums. A man, named Thomas Hartland, was discharged from Burntwood in May. In September he shot and killed a man named Davis. Subsequently he shot and killed a tramp who was sleeping by the roadside. Then he shot the

landlord of a public-house, and finally shot himself, and died shortly after. Shortly after, a woman attacked and killed another woman who was a stranger to her. A man saw a woman, a stranger to him, lying on the grass, at Glasgow Green, and forthwith beat out her brains with a hammer. At Doncaster, an Irish labourer, named Forde, while sleeping in a room with seven other men, suddenly began stabbing his fellow-lodgers with a large knife. The case of Saunderson, a youth, who had been at Normansfield, and who murdered a woman in the street, will be fresh in the minds of our readers. Almost all of these disasters have been made occasions for attacks in the newspapers upon the Lunacy Law for the obstacles it places in the way of removing lunatics to, and detaining them in asylums, and upon medical men who have charge of the insane for allowing such homicides to be at large. Whenever an untoward event happens in which a lunatic, or "alleged lunatic" is concerned, the newspaper press immediately clamours for an alteration in the Lunacy Law. To a bystander it appears obvious that no alteration in the Lunacy Law will prevent the occasional transmission to an asylum of a patient as to whose insanity different experts will entertain different opinions; nor the occasional discharge of a patient who may subsequently become homicidal. What is really required is a short Act of Parliament enacting, under the severest penalties that can be devised, that every medical man practising in insanity shall be compelled to have absolutely faultless judgment and absolutely unerring and unlimited foresight. If this simple measure were only enforced, it is possible that some of the cases recorded above might not have occurred, though we are bound to admit that some of the homicides appear never to have come under the observation of an alienist at all until after the crime. Let us therefore have another Act of Parliament providing that all persons who are likely to become homicidal lunatics shall present themselves periodically at the nearest lunatic asylum for examination. Nothing is so simple as to remedy evils by Acts of Parliament.

Reg. v. Covington.

The accused was cousin to the deceased, who was in domestic service in the town of Bedford, and who on the 13th June spent the evening with the father and mother of the prisoner, and with the prisoner at their house. Prisoner and deceased, who were "keeping company," appeared perfectly friendly throughout the evening. The girl was leaving to go home, when the prisoner followed her into an outer room, and fired at her three shots from a revolver with fatal effect. Immediately after he was found bending over her, kissing her, and calling her his wife. Being asked who did it, he said "I did," and further that he did it because he was in trouble. It was proved that a grandmother, an aunt, and a cousin of the prisoner had been insane; that in 1883 his health broke down so that he had to leave his employment and take three years' rest; that he then took other employment, during which he complained of constant pains in the head, and that he left that employment in consequence; that he took and left on account of his health a third employment; that since 1887 or 1888 he had done no work at all; that he had complained from time to time of his head; that he had become very eccentric and depressed; that he would remain for six weeks together in the house and see no one; that he would very often lie in bed all day, and very often go out in the middle of the night; that at these times he would say, "No tongue can tell what I suffer with my head."

Dr. C. G. Johnson gave evidence which amounted to this—that the symptoms above described were consistent with insanity, and that if the prisoner displayed no discoverable insanity after the crime, that was not inconsistent with his having been insane at the time.

Dr. Swain, Medical Superintendent of the Three Counties' Asylum, said that he had examined the prisoner, and came to the conclusion that he was "quite sane, and in his right mind, as far as he could judge." His examination took place four months after crime.

Dr. R. H. Kinsey, surgeon to the Bedford Gaol, deposed that the mental condition of the prisoner had been remarkably even. He had shown no signs of excitement and no signs of depression.

The Judge pointed out that insanity was a permanent condition of the mind which rendered a person unaccountable for his actions. An occasional flash of wildness did not constitute insanity. It would be a terrible thing if some of the theories advanced by the prisoner's counsel were made the law of the land. Because a person had relatives whose mental capacity was not very great, it was no reason why he should be allowed to take other people's lives with impunity. The only question for the jury to consider was whether the prisoner was insane at the time he committed the murder. The jury found the prisoner guilty, and added a strong recommendation to mercy.

The recommendation appears to show that the jury did attach importance to the testimony as to the insanity of the prisoner, for there was no other factor in the crime that appears to call for mitigation of punishment. At the same time the evidence of Drs. Swain and Kinsey left them no alternative to a verdict of guilty. It will be observed that according to the report, which is a very full one, the question left to the jury was not whether the prisoner "knew the nature and quality of his act, etc.," but "whether he was insane at the time he committed the murder." This is in accordance with previous practice of the same judge.—Bedford Autumn Assizes (Mr. Justice Day).—"Bedford and County Record," November 16.

In spite of the recommendation of the jury, the convict was executed.

Reg. v. Stephens and Stocks.

Richard Stephens, 70, Chairman of the Bournemouth Bench of Magistrates, Deputy-Lieutenant, etc., and Walter Stocks, 27, ex-police-constable, were indicted for sodomy and for gross indecency. The former charge was not proceeded with; to the latter both pleaded guilty.

There being no defence, evidence was called in mitigation of punishment and to character. Mr. Thos. Bond, on behalf of Stephens, deposed to the extremely feeble bodily health of the prisoner, and to a certain degree of mental weakness. The prisoner was in an intensely emotional condition—crying and sobbing and squeezing one's hand. From reading the letters, and from interviews with the prisoner, witness had no doubt that prisoner's mind was in a disordered condition—that it was not under proper control. His whole being seemed centred in a gross sort of immorality, which appeared to occupy all his thoughts. For sexual passion to be revived at so advanced an age (the Judge: "It was not *sexual* passion") was in itself a morbid condition, and it was a common experience that when this passion did so reappear at an advanced age it sought expression in unnatural ways, was accompanied by an inclination towards the same sex. It appeared that the prisoner suffered from phymosis, and this would have a tendency to keep up irritation and to aggravate his sexual tendency.

Dr. Mercier gave similar evidence.

The Judge, in giving sentence, thus addressed the prisoner: "It has been suggested to me that this is an outbreak of some sort of senile madness for which you are only half responsible. It is melancholy to have to listen to such nonsense when applied to a case like this. The very long correspondence satisfies me that you were able to take the utmost care that you could to prevent this thing being known, and I cannot believe for an instant that a decent-minded man would suddenly break out in his old age into filthiness of an indescribable character such as this has been. It would add a new terror to the fact of growing old, to which we must all of us submit, and, as applied to this case, that kind of suggestion is equally mischievous and ridiculous."—Winchester Autumn Assizes (Mr. Justice Wills).—"Hampshire Chronicle," Nov. 23rd.

The case was very similar to one described at the last meeting of the British Medical Association (Psychological Section). In both cases there was recrudescence of sexual passion in advanced age; in both the passion took the abnormal form of inclination towards the same sex; in both it sought expression in letters of indescribably filthy character and of enormous voluminousness and frequency. The main difference was that, in the case read in the Section, the letters were left about indiscriminately for anyone to pick up and read, and no sort of conceal-

ment was practised with regard to them, while, in the case of Stephens, he repeatedly urged upon his correspondent the necessity of destroying the letters. In the one case the judge decided that insanity was "proved up to the hilt;" in the other the judge, as we have seen, would not entertain the plea for a moment.

Reg. v. Hay.

At the same Assizes William Hay was indicted for attempting to murder his wife by putting oxalic acid in her tea on October 24th. It was proved that he had been six times in asylums in three years. Dr. Bland, Superintendent of the Milton Asylum, deposed that prisoner was discharged sane from that institution on August 14th. He saw prisoner in the Police Court, and considered that then and now prisoner was sane. Admitted he might have been insane on October 24th and have since recovered. Dr. Carrington, of Kingston Prison, who had had prisoner under his charge, considered the prisoner to be sane. No expert-evidence was called on behalf of the prisoner, who defended himself with considerable skill. The jury found him guilty, but insane.—Winchester Autumn Assizes (Mr. Justice Wills).—"Hampshire Chronicle," Nov. 23rd.

A remarkable instance of a verdict of insanity given in the teeth of the medical evidence.

Reg. v. Larking.

Harriet Sarah Larking was indicted for perjury and forgery. The defendant lodged with a Mrs. Brett from 1890 to May, 1894, when they had a disagreement about money matters and parted, and Larking then sued Brett in the Chancery Division, and asked for an account of the monetary transactions between them. On May 11th Larking applied for a summons against Brett for extorting £16 by means of a threat. Her story was that Mrs. Brett had met her in the High Street of Ventnor and had said, "If you don't bring me £20 within twenty-four hours I will expose you for forging a cheque." Larking stated that she was greatly alarmed, borrowed £10, added £6 of her own, and handed the money to Brett, who subsequently sent her a receipt, which she (Larking) produced in Court.

Brett was committed for trial, and tried before Mr. Justice Grantham on June 26th of this year, and at her trial Brett proved an *alibi*, and it became manifest that the receipt alleged to have been given by Brett was in the handwriting of Larking. Larking also confessed to having altered the amount on a cheque, and to having falsified Brett's bank book. The judge thereupon impounded the documents and ordered this prosecution.

At the second trial, that of Larking, it appeared that the prisoner had forged two cheques by altering them respectively from £3 to £300 and from £5 to £500. The defence was that the prisoner was, at the time of commission of the offences and from an early age, insane. She had in early life been under the care of Dr. Langdon Down. During the first eighteen months of her stay with Mrs. Brett she had behaved normally, but then became subject to fits of frenzy, in which she was violent and threw things about. Her father had on three different occasions been medically advised that his daughter ought to be placed under control, but had shirked the responsibility. Dr. Rees Phillips deposed that prisoner had been under his care since September 19th, and was, in his opinion, insane. In answer to the judge, he said that, in his opinion, the insanity dated far enough back to cover the transaction (in May) of which she was accused. To counsel for the prosecution he said that he thought that "the prisoner would have known what she was doing and yet would be so insane as to be unaccountable for her actions." Dr. Moore, of the Holloway Sanatorium, deposed that he should not at first have been prepared to certify the prisoner, but that he could do so now, and could say that the insanity had been long in existence.—The Judge: I suppose that a person in this condition from childhood would be in a very unfortunate condition for acquiring an accurate knowledge or distinction between right and wrong?—A.: Yes.—His lordship then put it to the jury to say whether, under the circumstances, they were not satisfied that this unfortunate young woman was not at all likely to acquire the perception between right and wrong, and the power of applying it, which others were able to do, and if on the evidence they were not satisfied that

she was insane.—The jury at once found the accused Guilty, but of unsound mind and not responsible for her actions.—Winchester Autumn Assizes, November 18th (Mr. Justice Wills).—"Hampshire Chronicle," November 23rd.

The above case is very remarkable in that the prisoner was found insane in spite of the elaborate and systematic character of the series of crimes that she had committed. She had altered several cheques so successfully that two of £3 and £5 had been actually passed through the bank and cleared for £300 and £500 respectively. She had concocted the elaborate story about the extortion of the £16, and had actually gone the length of not only applying for and procuring a summons, but of prosecuting at the Assize. A more hopeless case for establishing the plea of insanity could scarcely be imagined. The experts who testified to the insanity had not seen the prisoner until four months after the offence, yet they were allowed to say that the insanity had extended back over that period, and one at least was allowed to state that in his opinion the prisoner was unaccountable for her actions.

PROBATE CASES.

Brown and Baker v. Pain. Sprake v. Day.

During the early weeks in November there were two cases in the Probate Court before Mr. Justice Barnes of interest to the Association. They were both questions in which the validity of wills was contested on the ground of insanity in the testators. In the first case, *Brown and Baker v. Pain*, the facts were briefly as follows:—A gentleman who had been employed as clerk in the Courts of Justice, and who for several months before the final breakdown in his mental health had been unfit for even simple copying work. When seen by an expert in June, 1894, he was suffering unmistakably from general paralysis of the insane in an advanced stage, so that he had no knowledge of time or place, and was quite incapable of taking care of himself or of recognising his duties and responsibilities. The real question at issue was whether within a short time (two or three weeks in fact) of that period he might have been able to dispose of his property. The trial lasted five days (see "Times," November 7th, 8th, 9th, 12th and 13th), and there was the usual amount of conflict as to the capacity of (Mr. Toogood) deceased at or about the end of May, 1894. There was only one medical witness to support the sanity of the deceased shortly before the time at which he made his will, and this witness was not particularly strong as to his mental capacity. On the other hand, a doctor who saw him frequently and Dr. Savage considered it very unlikely that deceased could have made a valid will at the time alleged. In cross-examination the latter witness was asked what he considered to be the points proving capacity in a testator, and he said that he considered the following to be essential:—First, a knowledge of the property to be devised; second, a knowledge of the relatives who might be benefited; third, a just appreciation of the testator's relationship to his friends and relatives; fourth, power of self-control, enough to prevent undue influence; and finally, memory of recent and more distant events. This definition was accepted by the judge and counsel as good and falling in with all legal judgments. Considerable stress in cross-examination was laid upon the periods of remission, or, as they were called, lucid intervals, which may occur in general paralysis of the insane, and Dr. Savage in cross-examination admitted that in general paralysis of the insane it is common to have intervals during which responsibility may exist to the full. It will be remembered that only last year the same question was raised (*re Crabtree*) as to the validity of a will made by a general paralytic during a remission, and it seems to be established that during lucid intervals testamentary acts may properly be performed. In the end the jury found for the will, which was made within so short a time of the full development of symptoms of general paralysis of the insane. This case once more bears out the common experience that an English jury will very rarely upset a fairly reasonable will on any grounds whatever, and that unless a very distinct insanity can be made evident before the drawing up of the will, the plea of insanity afterwards will be of little value.

In the other case a compromise, which so often occurs in these Probate cases, prevented any point of medical or legal interest being decided. It was the case of *Sprake v. Day*. In this case again a man who undoubtedly was insane, suffering from general progressive dementia, associated with age, made a will in June, was markedly demented in July, and died in the autumn, and yet because the provisions of the will were not unreasonable, it seems pretty certain that if a compromise had not been made the will would have been upheld.

ATTENDANT KILLED BY PATIENT AT THE CANE HILL ASYLUM.

An inquest was held on the 27th September last on an attendant named Finch, who had died from injuries of the head received in attempting to overpower a patient who had climbed on to the roof of the asylum, from an airing court, by means of a stack pipe. Finch voluntarily ascended to the roof and was unfortunately unhelmeted by a first blow from the patient, who was armed with a piece of board, a second blow inflicting the fatal injuries.

This occurrence emphasises the desirability of rendering pipes in such situations unclimbable, and suggests the desirability of placing on record the various plans which have been adopted under similar circumstances to retrieve the patient.

The use of the fire-hose was not resorted to in this case from fear of washing the patient off, although this has often been successful. In one recent case, the patient, left to himself, came down voluntarily, and in another a bribe of beer and tobacco proved efficacious.

This case was quoted in the October number of the *Journal* as an example of the necessity of obtaining power, by the County Councils, to make grants to the wives and children of attendants losing their lives in the performance of duty.

CONFERENCE AT WAKEFIELD ON THE CARE OF HARMLESS LUNATICS.

A conference between the members of the General Asylums Committee of the West Riding County Council and representatives of Poor Law Unions within the Riding, was held on November 11th, at the Town Hall, Wakefield, for the purpose of considering the best means of providing for harmless pauper lunatics. The alternative suggestions appear to have been: (1) Increasing the accommodation of existing asylum; (2) building a new asylum "of a simple and homely character" for patients of this class; (3) providing accommodation in workhouses. A fourth possible alternative, that of boarding-out such patients, does not appear to have been mentioned. No definite conclusion was arrived at. The majority of the guardians who took part in the discussion were opposed to the return of patients from asylums to workhouses.

Whatever course may be taken, we trust that the proposal for increasing the accommodation of the existing asylums will not be adopted. They are already quite large enough, and the policy of enlarging the number of patients in an asylum beyond that for which it was originally built is a bad one.

THE BENCH AND LUNACY CASES.

The annexed extract from the *Sussex Daily News* is worthy of the attention of those concerned with the admission of patients to asylums:—"At the close of the ordinary business before the Bench Mr. Parsons, Clerk to the Thakeham Board of Guardians, said he had been directed by his Board to make application respecting the decision of the Bench in regard to lunacy cases. The Board regretted that the Bench had come to the decision that in future any appointments with Justices in regard to such cases should be made through their Clerk, so that he could attend. He was directed to ask the Bench to reconsider the matter.—Mr. West said without the Magistrates' Clerk in attendance it put the Magistrates in an extremely inconvenient position, having to act without any advice. He had himself acted without the Magistrates' Clerk very much against his will, but the

Bench thought in arriving at the conclusion they did that that ought not to be.—Mr. Parsons said that as regarded the expense the Magistrates knew too well the great cost which had to be incurred at the present time in sending cases to all parts of England, and of course if the proceedings passed through the hands of the Court certain fees which would be incurred would increase the present great cost.—The Chairman said he should not take a lunacy case without the Clerk.—Mr. Parsons asked if the Magistrates would consider the matter again?—Mr. Flowers said Mr. Parsons, from what he had heard, could gauge the feelings of the Magistrates, whereupon Mr. Parsons withdrew.”

It will be noticed that the protest against increased expense being incurred in the proceedings before justices in connection with lunacy cases comes from a Board of Guardians, but presumably the Sussex justices intend their decision as to the attendance of the Clerk to apply to private cases as well as pauper, and thus organised delay and expense will be put in the way of petitioners applying for reception orders. We cannot think that it was ever intended that the Lunacy Act of 1890 should be interpreted thus, though possibly the action of the justices may be within the wording of the Act. It would be desirable to have an explanation from someone with authority to give it as to what is meant by sec. 4, sub-sec. 2, which states, “The order shall be obtained upon a *private* application,” etc. Sec. 6, sub-sec. 3, further states: “The petition shall be considered in *private*.”

We are afraid, however, that the justices can take refuge behind sec. 9, sub-sec. 2, which enacts that the judicial authority “shall be assisted, if he so requires, by the same officers” as if he were acting in the exercise of his ordinary jurisdiction, and that no protest, therefore, is of any use. That there is a tendency in some justices to inflict unnecessary expense on the relatives of a patient may be illustrated by a recent case, in which, although the justice was satisfied with the *bonâ-fides* of the certifying medical man, and although he saw the patient and observed that she was acting unreasonably, yet he refused to make a reception order until his own medical man was called in, who signed a third certificate, *for which the relatives of the patient paid a fee of one guinea.*

PENSION SCHEME OF THE LANCASHIRE ASYLUM BOARD.

A Committee of this Board, appointed to consider the pension question, has drawn up a report, which has recently been adopted at a general meeting of the Board.

The age limit of fifty-five is adopted, but pensions at an earlier age may be given under special circumstances, and the rule of compulsory resignation at sixty is similarly elastic.

The scale of pension may be varied from one-third of the salary alone to the full two-thirds of the salary and emoluments, the actual pension within these limits being left to the recommendation of the Asylum Committee concerned.

If this scheme is applied in a liberal spirit it will be hailed with satisfaction, but some experience of its working will be required before expressing any strong opinion in regard to it.

It is certainly an improvement on the no pension scheme, with which Lancashire was threatened.

CORRESPONDENCE.

From Dr. Jules Morel, Ghent.

In reference to the discussion on “Forcible Feeding,” published in the *Journal of Mental Science* in October, I desire to communicate the method which I have used here for many years.

Having exhausted all means of persuasion, I make a signal to the attendants, who are trained to place the patient in bed in a horizontal position. One holds the knees firmly to the mattress, another, standing at the top of the bedstead, fixes the head between his hands. A third and fourth attendant, stationed on each side, hold the shoulders and forearms. The patient having been thus dealt with, without a word passing, the physician pours the liquid food at 98° Fahr. down either nostril, little by little, by means of a small spoon.

The food is composed of milk and yolks of eggs, and the quantity given at first never exceeds the contents of a wine glass. It is not repeated until one is convinced that the patient easily digests what he has already got. The patient is fed at least four times a day, and oftener as may be required. My experience is that the insane tolerate a monotonous diet of this sort for a long time, and it is seldom necessary to alter its constitution. I believe that in this form we have a liquid food of the highest nutritive value, and I never have recourse to pounded meat or other alimentary constituents in a suspended form.

Patients in general do not like this method of feeding, although they prefer it to the passage of nasal or œsophageal tubes. It often happens that they recognise, after one or two feedings, that it is better to take nourishment voluntarily.

The prognosis in a case persistently abstinent seems to me to be always unfavourable. On the other hand, if digestion is active and the body weight increases, one may look for a return to normal feeding within a short time.

Should vomiting occur as a rare complication, a few drops of chloroform added to the nutritive liquid will prevent it.

It is well known that forcible feeding is now practised much less frequently than formerly. Much more attention is given to the physical conditions which might reasonably give rise to refusal of food. Not until they have been searched out and treated should one think of proceeding to that extremity.

From Dr. Batty Tuke, Saughton Hall, Edinburgh.

In your review of Dr. Albrecht Paetz's work on "The Colonisation of the Insane in connection with the Open-Door System," in the October number of your Journal, you allude to the Twenty-third Report of the General Board of Commissioners in Lunacy for Scotland.

In justice to the management of the Fife and Kinross District Asylum, I beg to draw your attention to the following paragraph contained in that report:—"Detached houses or limited sections of the main buildings, the inmates of which consisted chiefly of patients requiring little supervision, have long been conducted in some institutions without locked doors. But the general practice of all large asylums has been to keep the doors of the various wards under lock and key. It was in the Fife and Kinross District Asylum that it was first recognised that this extensive use of the key is unnecessary, and that its disuse is attended with considerable advantage to patients" (p. xxxii.). This sentence is followed by a page of remarks expressing approval of the practice. You endorse Dr. Paetz's opinion that the open-door system is an important advance in the management of the insane.

I am aware that the unlocked door is only a part of Dr. Paetz's general system—still a not unimportant part. I therefore think that, in justice to the Scottish Asylum in which it was first adopted, the fact might be stated that the "open-door" system was commenced in the Fife and Kinross District Asylum in the year 1871.

From Dr. Bywater Ward, Warneford Asylum, Oxford.

I do not know whether there are any recorded instances of hæmatoma of the ear in animals. I have, however, lately observed a well-marked hæmatoma of the left ear of a half-bred Persian cat. It occurred soon after she had produced kittens, and without the slightest sign of any injury having caused it. This particular kind of cat is said to be specially subject to epilepsy, and I find that this one had several fits when about half-grown. As far as can be discovered she has had none for a long time, and there has been no noticeable peculiarity other than the hæmatoma which is now shrivelling, mostly at the anterior part.

From Dr. R. S. Stewart, Glamorgan Asylum.

Permit me to direct attention to two inaccuracies regarding the new Rules of the English Commissioners, which appear in the last number of the Journal, p. 696.

1. "Records of medicines prescribed need *no longer* be inserted" (Journal).— "Entries . . . recording the *medical* and other *treatment* with the results *shall* be made in the case-book" (Rule 13).

2. "Continuation orders of patients whose reception orders are dated on or *after* February 1st, 1890, are to be included in one list. *All others* are to be made *separately*" (Journal).—"With respect to patients whose reception orders were dated on or *prior* to the first day of February, 1890, the special reports and certificates . . . shall be included in one list . . . and with respect to patients whose reception orders are dated *subsequently* to the first day of February, 1890, a special report and certificate . . . shall be made and signed for *each* such patient . . ." (Rule 26).

[1. "*The medical and other treatment*" is to be recorded, but it is *no longer* necessary to keep "*an accurate record of the medicines administered,*" i.e., to copy the prescriptions. 2. "*On or after*" has been inadvertently used for "*on or prior.*"—*Ed.*]

A MONSTROUS SUGGESTION.

Under this heading we commented in our last issue on the Report of a Committee of the Medico-Legal Society of New York on certain proposed amendments in the Law of "Commitment of the Insane." We are now informed by the Chairman of the Committee that the suggestions which we stigmatised, and justly stigmatised, as monstrous, formed no part of the recommendation of the Committee, but were parts of an amendment which the Committee refused to approve or recommend.

The Committee have, however, only themselves to thank for the error into which we were led, for their report was drawn up in such a form that no person who was not present at their proceedings could come to any other conclusion than that at which we arrived. The following is the form in which it is made:—

"*Resolved* . . . The existing law is as follows. [Here the terms of the existing law are set forth.]

"The proposed amendment is as follows. [Here the proposal which we characterised as monstrous is set forth.]

"All of which is respectfully submitted.

"[Here follow the signatures of the members of the Committee.]"

We regret that we should have been led into error, and should have ascribed to the entire Committee a proposal which emanated from one of its members, and was not adopted by the Committee as a whole; but in view of the form of the report, and the plain statement that "the foregoing paper was read and considered, and after debate was unanimously approved by that Committee," we do not see how the error could have been avoided. We willingly publish this explanation of what appeared to be a grievously wrong finding, and refer our readers to page 42 *et seq.* of the "Medico-Legal Journal" for June, 1895, where the following resolutions are set forth:—

"1. That the present law is faulty in permitting any citizen to be committed and confined in an asylum, public or private, or in any institution, home, or retreat for the care and treatment of the insane, upon the mere certificate of two physicians under oath. 2. That such a commitment made in this manner, before it has been approved by a court or judge of competent jurisdiction, is in direct violation of the organic law of the State, and of the United States. 3. That the qualifications specified in the law, as it now exists, as to the competency of the certifying physicians, requiring only three years' actual practice of his profession, and without requiring evidence of his experience in or practical knowledge of insanity, are entirely inadequate to protect the liberty of the citizen. 4. That the statutory qualifications of the certifying physicians, as now stand in the law, would not be sufficient to enable said physician to testify as an expert in a court of justice where the question of insanity was at issue. 5. That in our opinion confinement of the insane in an asylum is not necessary, beneficial, or even prudent in all cases, and that before a judge signs a warrant of commitment, the

law should require him to be satisfied, by competent evidence, that the insane person, if at large, would be dangerous to himself or others, or that treatment in an asylum would be beneficial to him. 6. That in all cases of doubtful insanity judges, before signing warrants of commitment for insane persons, should assign counsel for the alleged lunatic when he is not otherwise represented. 7. That in our opinion, in the matter of commitment of the insane, the duty of medical men should be limited to giving medical evidence, and the responsibility for the commitment should rest upon the judge, and not upon the physician; that the medical profession has greatly suffered in public estimation by the practical working of the existing law, which throws upon the certifying physician the opprobrium of unfortunate or ill-advised commitments."

HACK TUKE MEMORIAL.

The subscriptions announced to September 10th amounted to £220 16s. 7d. Further subscriptions have been received from:—

	£	s.	d.
Dr. Spence Watson	1	1	0
Dr. Miles (N.S.W.)	1	1	0
Dr. Mercier	5	5	0
Dr. Rayner	5	5	0
Dr. E. M. Courteney	5	5	0
Dr. Oscar Woods	1	1	0
Dr. Rogers	2	2	0
Dr. Bevan Lewis	2	2	0
Dr. J. Rorie	2	2	0
Dr. Blandford	5	5	0
Rev. H. Hawkins	1	0	0
Dr. Chisholm Ross	1	1	0
Dr. Von Speyr	2	0	0
Senateur T. Roussel	20	francs	
Dr. Jules Dagonet	10	„	
Dr. Vallon	5	„	

H. RAYNE, Hon. Treasurer.

OBITUARY.

Death of Mr. Palmer Phillips.

We regret to report the death of Mr. Charles Palmer Phillips, Commissioner in Lunacy, at Elstree, on September 27th, in his 74th year. He was a son of the late Mr. William Edward Phillips, Governor of Prince of Wales's Island. Born in 1822, he was educated at Eton and Oxford, and was called to the Bar in 1846. He was principal secretary to Lord Chancellor Chelmsford in 1859, was a Revising Barrister for the City of London in 1864, and secretary to the Commissioners in Lunacy from 1865 to 1872. In the latter year he was appointed a Commissioner, and held the office until his death. He was the author of works on "Copyright Law" and "The Law Concerning Lunatics." His death removes a personality familiar to every Asylum Superintendent, many of whom can bear testimony to the kindly, courteous, and efficient discharge of his official duties, in which he took a keen, intelligent, and philanthropic interest.

Robert Jamieson, M.A., M.D. Aberdeen.

By the death of Dr. Jamieson on the 17th November, Scotland has lost her oldest Asylum Superintendent. A man of handsome presence, marked intellectual power, independent character, and genuine kindness of heart, Dr. Jamieson was an ideal physician. He was much and widely esteemed, and throughout the course of a long life proved a strong influence for good.

He was born in Aberdeen in 1818, graduated in Medicine there in 1839, and was shortly afterwards appointed Resident Medical Officer to the institution where he so long laboured. On his marriage in 1846 he resigned and engaged in private practice, but returned to his position in the asylum by the unanimous wish of the Directors in 1853, a position which he held till 1881, when Dr Reid was promoted to be his coadjutor. In 1884 Dr. Jamieson was released from active responsibility and remained in residence as Consulting Physician, since which time he has been but little known to the younger members of the specialty.

In 1840 the daily number resident in the Aberdeen Royal Asylum was 144, at present it is 730; and Dr. Jamieson's wisdom and foresight in dealing with successive additions to the responsibilities of his office have always been adequately recognised by those who had the good fortune to be associated with him.

In a contemporary notice, we find Dr. Jamieson credited, along with Dr. Hutchings, of Glasgow, with introducing the "non-restraint" system of treatment into Scotland; but that he was no mere theorist his own words, from the annual report of 1841, will show—"In regard to the subject of coercion . . . we find ourselves called upon, in justice to the managers and to the friends of the patients under our charge, to make a short statement of our practice in this important particular, and it, shortly, is this, that we act on the principle of *non-restraint*, as far as the construction and economy of the establishment will allow; but we have no desire to obtain the notoriety of being non-restrainers at the expense of what we conscientiously deem to be for the safety and advantage of our patients. That there are cases in which mild restraint is both judicious and humane every physician who is unprejudiced must surely admit who has ever witnessed the unbridled violence of an outrageous maniac, exhausting the excited vigour of an enfeebled constitution, and extinguishing the hope of recovery for ever. We have no more hesitation in such cases, when other means have been useless, in applying the waist-belt or the muff than we would have in applying leeches or a blister against the will of the individual It is scarcely requisite now that the public mind entertains less prejudiced notions on the treatment of the insane to notice that threatening and abusive language and harsh measures of every description are not only found to be unnecessary, but strictly prohibited among the attendants, and made the occasion of reprimand or dismissal when discovered."

While in private practice, Dr. Jamieson occupied the chair of Lecturer on Practice of Medicine and Medical Jurisprudence in King's College, Aberdeen, and took that opportunity of delivering systematic lectures on insanity, thus leading the movement which has now become so general. The lectures were published in the "London Medical Gazette" for 1850, and will, even yet, repay the attention of the specialist. A discourse on Mind and Body (*Phrenical Action of the Cerebrum*, "Journ. Psych. Med.," 1858), read before the Philosophical Institution of Aberdeen, deals with the subject from a more popular point of view.

Dr. Jamieson was pre-deceased by all his family, and bore his sorrows with that manly fortitude for which he was distinguished. In private life he was known as a man of cultivated tastes, and, indeed, at one time he was ambitious of becoming an artist. He had a notable artistic and musical talent, and has left a valuable collection of works of art. His portrait has been painted by three men of note, Sam Bough, John Pettie, and Sir George Reid; and his handsome, kindly face lives on canvas.

Dr. Jamieson became a member of the Medico-Psychological Association in 1859, and his contemporaries recognised him as a gentleman whose counsel and encouragement were to be highly appreciated.

Professor Ardrea Verga.

The death of this distinguished physician on the 21st November, at the advanced age of 84, deprives medico-psychological science of a most distin-

guished and original worker. His long connection with the asylums of Milan afforded him opportunities which he used skilfully and wisely. As Professor of Psychiatry and as President of the Lombard Institute of Science and Literature, his worth has been acknowledged in Italy; while his fame as an original and independent thinker secured his recognition by learned societies all over the civilised world. His work on "Hallucinations" received the prize of the Académie de Médecine de Paris, and his writings on "Criminality" anticipated many of Lombroso's ideas. Professor Verga long ago advocated the special care of insane criminals, and he strongly emphasised the propriety of dealing with habitual offenders as moral imbeciles. His lectures were attended by all sorts and conditions of medical men, and the loss of his interesting personality is a heavy blow to science.

NOTICES.

THE PRIZE DISSERTATION.

The President has suggested the following subjects for the Bronze Medal and Prize of ten guineas, which is open to all Assistant Medical Officers of Asylums, but Candidates are at liberty to present an Essay on any other subject if they so desire:—

1. Testamentary Incapacity from a Medico-Psychological Standpoint.
2. What is the Influence—if any—of Alcoholic Intemperance as a Primary Cause of Insanity?
3. The Pathological Changes in the Blood Vessels of the Brain Cortex in Insanity.

DATES OF NEXT MEETINGS OF THE ASSOCIATION.

The next General Meeting will be held on Thursday, 20th February, 1896, probably at Cambridge, as Carlisle is to be the place of meeting of the British Medical Association in July, 1896.

The Spring Meeting of the South-Western Division will be held on the afternoon of Tuesday, 14th April, 1896, at Barnwood House, Gloucester.

The Spring Meeting of the Scottish Division will be held on Thursday, 12th March, 1896, at Glasgow.

The Spring Meeting of the Irish Division will be held in Dublin, in April, 1896.

INTERNATIONAL CONGRESS OF PSYCHOLOGY.

The third Congress will be held at Munich from 4th to 7th August, 1896, under the presidency of Dr. Strumpf, of Berlin. The Committee includes the names of Professors Bain, Ferrier, Schäfer, Sedgwick, and Sully.

All psychologists and educated persons are invited to attend. The forms of application for membership can be obtained from the General Secretary, Dr. Shrenk-Notzig, München, Max-Josephstrasse 2, or from Professor Sully, East Heath Road, Hampstead. The subscription is 15 shillings.

The programme of work includes:—

- I. Psycho-physiology—A. Anatomy and Physiology; B. Psychophysics.
- II. Psychology of the Normal Individual.
- III. Psychopathology.
- IV. Comparative Psychology.

Psychologists intending to offer papers or addresses are requested to state the subject of their communications, and to send written abstracts of them to the General Secretary, at Munich, before 15th May, 1896.

APPOINTMENTS.

MR. HARDINGE FRANK GIFFARD has been appointed Secretary to the Commissioners in Lunacy in the place of Mr. G. H. Urmsen, who has been appointed a Commissioner.

DR. D. NICOLSON has been appointed Lord Chancellor's Visitor in Lunacy, vice Dr. Lockhart Robertson, retired.



JOURNAL OF MENTAL SCIENCE.



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Samuel Hitch, M.D.

First Secretary and Chief Organiser of the Medico-Psychological Association.

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VOL. XLII.

PART I.—ORIGINAL ARTICLES.

The Early History of the Medico-Psychological Association.
By T. OUTTERSON WOOD, M.D., F.R.C.P.Ed., M.R.C.P.
Lond.

Our Association, which celebrated its jubilee at the Annual Meeting held at Birmingham in 1891, under the presidency of Mr. Whitcombe, numbers but few members who know much about its origin, formation, and early history, and it has occurred to me that it might be well if a record of it could be obtained and published while there yet remain among us some of the survivors of its earlier days. It will always be a regret to me that this was not taken in hand before the death of our greatly lamented colleague, Dr. Hack Tuke, who was one of our oldest and most devoted members, for he knew so much about its past history, and was personally acquainted with most, if not all, of the original members. Sir John C. Bucknill is, as far as I can ascertain, the sole surviving member of the Association in the days when the roll of members was a very small one, numbering between 30 and 40 at most, and his name first appears in our records in 1849.*

In connection with this subject my first intention was merely to make out a list of the Presidents of the Association from its foundation to the present time, in order that their names might be printed annually in the October number of the *Journal of Mental Science*, but on looking over the available records I discovered that up to 1854 there were no

* Dr. Huxley, of the Kent Asylum, and Mr. Holland, then of Surrey, and subsequently of Whittingham, both attended a meeting at the Warneford Asylum, on June 23, 1847, but neither of them are members of the Association now. I have, unfortunately, been unable to gain any information from them.

Presidents, and that a Chairman was chosen at each meeting. Next year the October number of the *Journal* will contain the names of the Chairmen who presided at the Annual Meetings from the first held in 1841 to the meeting of 1854, when it was resolved that the Chairman of the Annual Meeting should in future be the President for the year.

It was in seeking for this information that a certain amount of ambiguity was found to exist, and I wrote to Sir John C. Bucknill to ask him if he could assist me by his recollection of past events to clear it up and to make the list more complete, suggesting also that perhaps it would be well to attempt to put together an account of the earlier meetings. In his reply he says, "It seems to me that it is quite worth while taking a little trouble to determine, as accurately as may be, the early history of our Association from recollections which are still available, but which in a very short time will naturally be beyond recall." Such is the object of this communication, and in carrying it out I have freely and literally, as far as possible, quoted from the minute book of the Association—firstly, because in the course of a little time, even with every care, it will become dilapidated; and, secondly, because it will thus afford an opportunity to members of the Association of knowing who the men were that inaugurated the Association, what was in their minds when they did so, and how they carried out the principles they sought to establish. In printing and circulating this record of our early history the danger of its being lost by any accident happening to the old minute book will be obviated, for it will be contained in every number of the *Journal of Mental Science* for April, 1896, in a complete though necessarily somewhat condensed form. No incident of any note has been omitted.

The first step towards the formation of an Association of the Medical Officers of Lunatic Asylums was taken in June, 1841, and was in the form of a circular. The reason given for the issuing of the circular is stated as follows:—"The advantage of co-operation on the part of medical gentlemen engaged in the treatment of the insane having been often the subject of conversation amongst those whom accident occasionally brought together, the following circular was addressed to each medical gentleman connected with a public lunatic asylum, and also to those attached to the more private and charitable establishments of the same kind."

Then follows the circular :—

Gloucester, June 19, 1841.

Dear Sir,—It having been long felt desirable that the medical gentlemen connected with lunatic asylums should be better known to each other—should communicate more freely the results of their individual experience—should co-operate in collecting statistical information relating to insanity, and above all should assist each other in improving the treatment of the insane, several gentlemen who have the conduct of lunatic asylums have determined on making an attempt to form “*An Association of the Medical Officers of Lunatic Asylums.*” For this purpose they propose to meet *annually* at the time and place “the British Association for the Cultivation of Science” shall select for holding their meetings, and to hold a first or preliminary meeting this year, on the 29th of July, at Devonport.

I have been requested by these gentlemen to learn how far their brethren will co-operate with them, and I shall feel it a personal kindness, therefore, if you will, as soon as possible, give me your opinion upon this proposed Association, and also inform me if you will give it your support.

I beg to remain, Sir,

Your obedient and faithful servant,

SAM. HITCH,

Resident Physician Gloucester General
Lunatic Asylum.

To Each Medical Officer of a Lunatic Asylum.

Eighty-eight circulars were sent out, forty-five replies from various Medical Superintendents were received in favour of the formation of the Association, and expressing their willingness to join, but only four were in favour of attending the proposed meeting at Devonport. The permission of the Visiting Committee of the Gloucestershire General Asylum was, however, obtained, and the Medical Officers of that institution invited those gentlemen who would have to pass through Gloucester on their way to Devonport to hold a preliminary meeting at the Gloucester Asylum on July 27th, 1841. At this preliminary meeting there were present Dr. Shute, Visiting Physician of the Gloucester Asylum (in the chair); Mr. Gaskell, Medical Superintendent Lancaster Asylum; Dr. Hitch, Resident Medical Superintendent Gloucester Asylum; Mr. Powell, Resident Medical Superintendent Nottingham Asylum; Dr. Thurnam, Resident Medical Superintendent York Retreat; Mr. Wintle, Resident Medical Superintendent Oxford Asylum (Warneford); and I take it that these gentlemen, therefore, may be looked upon as the

actual founders of the Association. The resolutions passed at this meeting were important, and as showing the objects they had in view I give them verbatim.

1. That it does not appear incumbent on those who issued the circular and convened the meeting to proceed to Devonport.

2. That this meeting considers itself competent to establish the Association proposed in the circular.

3. That an Association be formed of the Medical Officers attached to Hospitals for the Insane, whose objects shall be *improvement in the management of such institutions, and the treatment of the insane and the acquirement of a more extensive and more correct knowledge of insanity*. That the medical gentlemen attached to Hospitals for the Insane be individually addressed, and requested to join the Association.

4. That by the members of this Association the terms *Lunatic* and *Lunatic Asylum* be abandoned, except for *legal** purposes, and that the terms "*Insane Person*" and "*Hospital for the Insane*" be substituted.

5. That to effect the objects of this Association visits be made *Annually* to some one or more of the Hospitals for the Insane in the United Kingdom, and that the order of rotation in which such visits shall be made be determined at the several meetings.

6. That the concurrence of the Governors of the several hospitals to this arrangement be solicited by the respective Medical Officers.

7. That at its meetings the Association ascertain, and record as far as possible, the medical and moral treatment adopted in each hospital.

8. That to ensure a correct comparison of results of treatment in each it is strongly recommended that uniform registers be kept, and that tabular statements upon a like uniform plan be circulated with the Annual Report of each hospital, or when this be not practicable that it be otherwise transmitted to the Association.

9. That at the meetings papers and essays be read; subjects of interest to the insane and to the Association be discussed, and information communicated; and that a copy or minute of these be preserved in the Journal of the Association.

10. That at the Annual Meeting the Senior Medical Officer of the hospital visited be Chairman.

11. That a Secretary be appointed to keep the journals, papers, etc., of the Association, and to perform the usual duties of such officer.

12. That the first Annual Meeting be held at Nottingham early in September next, of which due notice shall be given.

3. That Dr. Hitch be requested to act as Secretary *pro temp*.

* Altered to "official" at subsequent meeting.

14. That these resolutions be printed and a copy forwarded to every Medical Officer of the Hospitals for the Insane in Great Britain, and, as far as possible, to the Medical Officers of similar establishments on the Continent.

These resolutions gave very clearly the objects and aspirations of the new Association, and to this day they remain the basis, and contain the fundamental principles upon which our present Association is established. Owing to "unforeseen circumstances," the first Annual Meeting could not be held at Nottingham in September as originally intended, and the meeting was postponed. On September 29th, at a meeting of the Committee of the Nottingham Asylum, it was resolved:—"That the Governors of this Institution, approving of the objects of the Association, willingly comply with Mr. Powell's request"—that the first Annual Meeting should be held there. Dr. Hitch, the Secretary of the Association, issued a circular calling the members together for the 4th November, and appended to this circular is the following postscript:—"N.B.—The first business of this meeting will be to consider the resolutions of the meeting held at Gloucester, next to frame rules and regulations for the future government of the Association, and finally to pursue the objects of the Association."

The following is the report of the proceedings at the meeting:—

At the first Annual Meeting of the members of the Association held by permission of the Governors of the Lunatic Asylum at Nottingham this 4th day of November, 1841, present: Dr. Blake (in the chair) (Nottingham), Dr. Corsellis (Wakefield), Dr. Crommelink (Bruges, Belgium), Mr. Gaskell (Lancaster), Dr. Hitch (Gloucester), Dr. Pritchard (Northampton), Mr. Powell (Nottingham), Mr. Prosser (Leicester), Dr. Shute (Gloucester), Mr. Smith (Lincoln), and Mr. Thurnam (York Retreat); the Rev. R. W. Wilson and Thos. Close, Esq. (Governors of the Nottingham Asylum), and Dr. Bowden (Hanwell), were admitted as visitors.

The minutes of the meeting at Gloucester having been read, a number of resolutions were passed bearing upon the management of the Association. These were to the effect: 1. That the Governors of the institutions where the meetings were held should be invited by the Medical Officers thereof to be present. 2. That the expression "*Medical Officers attached to Hospitals for the Insane*" should be meant to include medical gentlemen attached to *private* as well as

public asylums. 3. That members should be elected by ballot, and notice of the name of each candidate should be sent to every member one month prior to the election,* 4. Who should be furnished with a ballot paper. 5. A majority of two-thirds of the members should be necessary to carry election. 7. Dr. Shute appointed the first treasurer of the Association. 8. The Annual Meetings were fixed for the first Thursday in June in each year. 9. Drs. Shute, Corsellis, Thurnam, and Hitch appointed a Committee to consider the best form of registers and tabular reports as recommended by previous meeting. 10. That this Association, as it may think proper, shall elect as honorary members gentlemen, whether medical or otherwise, who shall have distinguished themselves by the particular interest they have exhibited in the subject of insanity; and 11. That Mr. Samuel Tuke (of York), Mr. Farr (of London), Dr. Bowden (of Hanwell), and Dr. Guislain (of Ghent), be now elected honorary members. 12. The annual subscription was fixed at one guinea. 13. The collection of plans of all the Hospitals of the Insane for the use of the Association agreed to. 14. That without pledging themselves to the opinion that *mechanical restraint may not be found occasionally useful in the management of the insane*, the members now present have the greatest satisfaction in according their approbation of, and in proposing a vote of thanks to, those gentlemen who are now engaged in endeavouring to abolish its use *in all cases*.

A vote of thanks to the Governors and Medical Officers of the Nottingham Asylum for inviting the Association to hold its *first Annual Meeting* in that establishment, and to Dr. Blake for presiding, terminated the proceedings.

The Association now seemed fairly launched and its prospects were bright. In the hands of our worthy predecessors the various resolutions so excellently framed and carried in such a business-like manner appeared to augur well for the success of the undertaking, and the second Annual Meeting showed no falling off in that respect. Keeping in view the fundamental principle that one of the objects of the Association was "that visits should be made annually to some one or more of the Hospitals for the Insane in the United Kingdom," we find that the second Annual Meeting was held at the County Asylum, Lancaster, on the second of June, 1842. The following were present:—Dr.

* This was altered at the following meeting.

de Vitre, in the chair (Lancaster), Mr. Gaskell (Lancaster), Dr. Corsellis (Wakefield), Mr. Thurnam (York Retreat), Mr. Powell (Nottingham), Mr. Prosser (Leicester), Mr. Smith (Lincoln) Mr. Bush (Gloucester), Dr. Hitch (Gloucester), Dr. Sutherland (St. Luke's, London). Visitors: The Rev. Mr. Umpleby, (chaplain, Nottingham), the Rev. Mr. Wilson (governor, Nottingham), Dr. Oliver (Carlisle).

After reading the minutes of the last meeting, which had already been signed by Dr. Blake, who was the chairman at that meeting, it was resolved that gentlemen desirous of becoming members of the Association should be proposed by two members for election by ballot at each Annual Meeting, thus altering the resolution on the subject of election of members passed at the last meeting.

2. Dr. Sibbald, of Maidstone, Mr. Burke, of Gloucester, and Dr. Dandairs, of Nottingham, were elected ordinary members. These gentlemen are the first whose election as ordinary members is recorded. 3. Mr. Wilson and Dr. Oliver, of Carlisle, were elected honorary members. 5. Mr. Fulljames, architect to the County of Gloucester, presented plans of the Gloucester Asylum, and (6) Mr. Smith a ground plan of the Lincoln Asylum. 7. Dr. Crommelink, of Bruges, presented the Society (through Mr. Powell) with a handsome copy of his *Nouveau Manuel d'Anatomie descriptive et raisonnée*.* Dr. Crommelink was thanked "for his handsome present." 8. A paper was read by J. Thurnam, Esq., "On the precautions necessary to be observed in reporting statistical observations," and he was thanked and requested to allow his paper to be printed and circulated among the members. 9. A letter was read from Dr. Mackintosh, of the Dundee Asylum, with regard to the dietary of his asylum, which it was proposed to reduce, and a resolution was passed deprecating any alteration in the dietary of that asylum either in point of quantity or quality "inasmuch as it is at present, especially as regards animal food, much below the standard in similar institutions." 10. The Governors of Public Institutions in the United Kingdom to be solicited to further the objects of the Association. 11. A month's notice previous to the Annual Meeting to be given of any proposed alteration of rules. 12. The Visiting Justices of the Lancaster Asylum thanked for leave to hold

* Can any member of the Association throw any light upon the whereabouts of this book, or Dr. Thurnam's paper?

the meeting there, and congratulated on the improvements made. Additional land suggested. 13. The form of registers prepared by Committee appointed at last meeting approved of. 14. The next meeting to be held in London. A paper on the Diet of Lunatic Asylums was received, after the meeting broke up, from Dr. Poole, of the Montrose Asylum.

I can find no record of anything worthy of note having happened between this and the following meeting; which, as will be gathered from the record of the proceedings, was one of the most successful meetings of the Association, extending over several days.

June 1st, 1843.—The third Annual Meeting was held at the British (or Morley's) Hotel, Trafalgar Square, London, and there were present: Dr. Conolly (Hanwell), in the chair, Dr. Sutherland (St. Luke's), Dr. de Vitre (Lancaster), Mr. Gaskell (Lancaster), Dr. Stewart (Belfast), Mr. Poynder (Kent), Dr. Pritchard (Northampton), Dr. Hitch (Gloucester).

At this meeting Dr. Thurnam was granted permission to print his paper, read at the last meeting. The Secretary reported that the Governors of the Hanwell, the Surrey, the Kent County Asylums, and St. Luke's Hospital had acceded to the request of the Association to visit them, but that the Governors of Bethlem had refused. A Committee was appointed, consisting of Dr. Sutherland, Mr. Gaskell, and the Secretary, to draw up a circular to be sent to the Governors of each Hospital for the Insane, informing them of the existence of the Association and the objects it seeks to accomplish. The register ordered by Resolution 13 of last meeting had been printed, 5,000 had been struck off, and 2,975 distributed. Including the cost of these the disbursements of the Association only amounted to £11 16s. 6d. for the year, so that the members were to be informed that in future no annual subscription would be required of them. The Secretary reported that he had collected a considerable number of asylum reports; also that he had had a correspondence with Lord Ashley on matters connected with the insane; had brought the Association under his lordship's notice, and had offered its co-operation, which he had accepted; and further that much useful information on "the effects of intemperance in the production of insanity" had been thereby collected. This is the first mention of the late Lord Shaftesbury's name in the

records of the Association. Dr. Hitch, the secretary, had evidently not been idle since the last meeting, for he now goes on to report to the meeting that he had also at the solicitation of several medical gentlemen connected with the Irish District Asylums addressed the Government on the want of a Resident Medical Officer in the establishments containing from one to four hundred patients, that his letter had been graciously received, and that a change had subsequently taken place in the management of the patients, which, though not the one desired, had much improved the treatment of the patients. The meeting passed a resolution approving of what Dr. Hitch had done, and added that they "wish to record their opinion that nothing can be more detrimental to the comfort and welfare of the insane than confiding the entire superintendence of asylums to those who are not members of the medical profession." Letters were read from Mr. Lloyd Williams, secretary *pro tem.* of the contemplated asylum for North Wales, and from Dr. Oliver, of Carlisle, with regard to the want of provision for the insane poor, and it was resolved that the meeting fully concurs in the observations of those gentlemen concerning the importance of more general and systematic provision for the insane poor. A communication was read from Dr. Correllis, of Wakefield, on the subject of inserting a clause in any new Act of Parliament empowering the visitors of County Hospitals for the Insane to grant retiring pensions to the officers. So that the pension question was first raised at this meeting, and now, fifty-three years afterwards, we find a pension scheme approved of by the Derby County and other asylums, thanks mainly to the action taken by Dr. Murray Lindsay and his continued exertions in that direction. The curious point here is that the meeting passed the following resolution:—"Resolved that the meeting does not think it expedient to take any steps on the part of the Association to forward the insertion of such a clause." It is evident that even thus early books, plans, pamphlets, etc., were accumulating in the hands of the Secretary, and that members were anxious to refer to them, for the meeting passed the following resolution on the subject:—"That any member of the Association be supplied with the works, plans, etc., in the care of the Secretary, upon application to him, provided always that he pay the expenses of forwarding to him and returning such work, plan, etc., to the Secretary."

Now that we possess the nucleus of a valuable library, which will increase rapidly as the members of the Association appreciate it, why should not some such plan as this be revived? It would give members, especially those living in remote districts, an additional interest in the work of the Association, and be the means of placing at their disposal many books which they might not otherwise be able to obtain. After electing two ordinary and fifteen honorary members, a paper was read by Dr. Oliver, of Carlisle, on "The expediency of a general method of recording the morbid appearances met with in the dead bodies of the insane." Dr. Oliver was thanked for his paper, but no resolution was recorded. Invitations were then given for the Association to meet at Hanwell by Dr. Conolly the following day, the 2nd inst.; by Dr. Sutherland to meet at St. Luke's on the 3rd; by Sir Alex. Morrison to meet at the Surrey Asylum on the 5th; and by Mr. Poynter to visit the Kent Asylum, Maidstone, on the 6th; and the meeting then adjourned to the following day at Hanwell. Of how the members concluded the evening there is no record. There is no mention of any dinner, nor of thanks to any member for having hospitably entertained them, as appears in the notices of other meetings.

At the adjourned meeting held at Dr. Conolly's house, in the Lunatic Asylum at Hanwell, June 2nd, 1843, there were present Dr. Conolly, in the chair, Dr. Sutherland, Dr. Stewart (Belfast), Dr. Davey, Dr. Begby, Mr. Gaskell, Dr. de Vitré, Dr. Pritchard, Mr. Poynder, Dr. Hitch, Dr. Formby, and, as visitors, Mr. Tulk, Mr. Devon, and Mr. Serjt. Adams. The asylum was visited. A paper was read by Dr. de Vitré on "The necessity for an extended legislative protection to persons of unsound mind." Dr. de Vitré was thanked for his paper, and his permission asked to permit it to be printed by the Association and to be distributed to the members of the Association, to the Visitors and Governors of Lunatic Asylums; to the Chairman of Quarter Sessions for each county; to the Poor Law Commissioners; and to Members of Parliament and others who are known to take a warm interest in the fate of the insane. The meeting then proceeded to pass the following resolution:—"That the Association, deeply impressed with a sense of the benevolent consideration shown to the condition of the insane by the Reverend Dr. Warneford on numerous occasions, and especially in his late most generous donations to the

Warneford Asylum, near Oxford, feel it incumbent upon them to offer him the expression of their respect and of the grateful feelings with which they are animated when reflecting on the benefits he has laboured to bestow on and to perpetuate for the sick and afflicted of every description, and more particularly for those visited with the dreadful calamity of insanity." That the Rev. Dr. Warneford and the Rev. Vaughan Thomas, who had been so much associated with him in his acts of benevolence, and the Rev. Mr. Umpleby, the worthy and zealous Chaplain of the Lancaster Asylum, be elected honorary members of the Association. Dr. Quick, of the Surrey Asylum, and Mr. Lute, of St. Luke's, were elected ordinary members, and the meeting adjourned.

At an adjourned meeting of the Association, held at St. Luke's Hospital, June 3rd, 1843, there were present Dr. Sutherland (in the chair), Dr. de Vitre, Mr. Gaskell, Dr. Philp, Dr. Stewart, Dr. Pritchard, Mr. Lute, and Dr. Hitch. The hospital was visited, and the minutes of the last meeting having been read, a letter was read from Dr. Wintle, of the Warneford Asylum, "directing attention to the value of creosote in doses of three minims and upwards in cases of dementia, in which it gives tone and acts altogether beneficially." Dr. Wintle also wished that the success which had attended Dr. Ogle's and his own use of opiates should be named. The meeting resolved itself into a conversazione on the respective experience of the members on the various forms of disease occasioning or accompanying insanity. The thanks of the meeting were given to the Committee of Visitors of Hanwell and to Dr. Conolly, the Committee of St. Luke's and Dr. Sutherland for having thrown open these institutions and receiving the members. Dr. Hitch spoke of the efficacy, and cited cases in proof, of iodine and its compounds in the depression consequent upon excitement; and Dr. Sutherland referred to the value of carbonate of soda in nymphomania, and cited cases. The meeting then adjourned.

At the adjourned meeting of the Association, held at the Surrey Asylum, June 5th, 1843, there were present Sir Alexander Morison, M.D., Dr. Quick, Dr. Stewart, Mr. Gaskell, and Dr. Hitch. The establishment was visited and was much admired for its cleanliness, tranquillity, and general good order. The designation of the female head of our Hospitals for the Insane, "Matron," being brought

before the meeting as highly objectionable in all cases, but more especially in those institutions where the patients are of different classes, and some of these of the higher class of society, from its leading the mind to an association with the female directress of a Workhouse, and it being proposed to make a change in this, the meeting thought it prudent not to invite the Association by any expression of an opinion on the subject, but suggested that in cases where it appeared to operate most offensively, the Medical Officers should use their efforts to induce the respective committees to make the required alteration in the name. It will be noted that no alternative title was suggested. With a vote of thanks to the visitors, Sir Alexander Morison and Dr. Quick, the meeting concluded and adjourned.

At the adjourned meeting of the Association, on June 6th, 1843, held at the Secretary's Rooms, Newman Street, Oxford Street—present: Dr. Stewart, Mr. Gaskell, and Dr. Hitch—a letter was read from Mr. Poynder announcing the sudden and serious illness of his lady, and it was resolved that the members do not proceed to Maidstone, as previously determined. It was recommended that Dublin should be the next place of meeting. A letter was read from Dr. Hutcheson, of the Glasgow Asylum, inviting the Association to meet there. The Secretary having procured the permission for the Association to visit the model prison at Pentonville, the members present visited it accordingly.

For some reason unknown the meeting was not held in either Dublin or Glasgow, but at York.

September 25th, 1844.—The fourth Annual Meeting of the Association was held at the Retreat, York. Present: Dr. Thurnam, of the Retreat (in the chair), Dr. Wintle (Oxford), Dr. Pritchard (Bristol), Dr. Formby (Liverpool), Mr. Tuke (York, honorary member). Visitors: Dr. Hodgkin (London), Dr. Fowler (Salisbury), Mr. Williams (Visiting Surgeon to the Retreat), Mr. Alderson (Medical Superintendent York Asylum), and Dr. Stewart (Belfast).

At this meeting Dr. Hitch was unexpectedly prevented from attending. Dr. Stewart was appointed temporarily to act for him, and the following resolution was passed: "That the best thanks of the Association be given to Dr. Hitch for his persevering services in promoting the interests and important objects of the Association since his appointment as its honorary secretary." A communication was read from Dr.

Julius, of Berlin, saying he was commissioned by Professor Damarow, of Halle, to present to the Association the first number of the Journal of the German Association, for which he was thanked.

A letter was read from Dr. Hynn relating to the general management of the Irish District Hospitals. Dr. Hynn was thanked for his letter, and Dr. Pritchard undertook to lay it before Lord Ashley and the other Commissioners. Dr. Thurnam and Dr. Wintle were appointed auditors, and the secretary *ex-officio* the treasurer. Mr. Falljames presented the Association with the plan of the new asylum for the County of Denbigh, and Mr. Fowler a plan of the Devon Asylum.

A Committee was appointed, comprising the auditors and secretary, empowered to call upon the members for a renewal of the annual subscription of one guinea as formerly fixed upon. The publishing of Dr. de Vitre's paper had cost more than was expected, and he was asked how far he was prepared to share the expense. Several ordinary members were elected, and Dr. Pliny Earle, of the Bloomingdale Asylum, New York, and Dr. Zeller Winnenthal, Wurtemberg, were elected honorary members. Mr. Tuke made some valuable remarks upon asylum construction, and Dr. Hitch was requested to communicate with Mr. Tuke in order that his observations might be printed and distributed. The meeting then adjourned.

An adjourned meeting was held on Friday, September 26th, 1844, at 2 p.m., at the York Asylum (Bootham?). Present: Mr. Alderson (in the chair), Dr. Thurnam, Dr. Wintle, Dr. Pritchard (Bristol), Mr. Williams, Dr. Belcombe, Dr. Stewart. Visitors: Dr. Morris and Dr. Davis.

The following papers were read: Dr. Crosse, of Norwich, "On Homicidal Mania;" Dr. Wintle, of Oxford, "On the Use of Opium and Narcotics generally in the Treatment of Acute Mania;" Dr. Oliver, Acting Resident Medical Officer of the Lancaster Asylum, "On the Proportion of Curable Cases and the advantages or otherwise of placing Chronic Cases in a separate establishment."

Dr. Thurnam was thanked for his hospitality in entertaining the members of the Association at the Retreat, and Mr. Alderson for receiving the members of the Association so hospitably at the York Asylum.

June 23rd, 1847.—Since the last meeting there is no record of any kind until this, the fifth Annual Meeting, held at the Warneford Asylum, Oxford, with Dr. Wintle

in the chair, and the following members present: Mr. Gaskell, Dr. Hitch, Mr. Ley, Dr. Oliver, Dr. Stewart, and Dr. Williams. The members inspected the building. The minutes of the previous meeting were read, and the following elected members: Mr. Broadhurst (Lancaster), Dr. Boyd (Somerset), Dr. Huxley (Kent), Mr. Monson (Norwich), Dr. Nisbett (Northampton), Dr. Begby and Dr. Hitchman (Hanwell), Mr. Walsh (Lincoln), Mr. Holland (Surrey), and Mr. Jones (Denbigh). These names are given because so many of them remained active members of the Association for many years and did good work for it.

The receipt of reports of American Asylums is noted, and members requested to forward to the Secretary copies of English reports for exchange. It was also resolved to have copies of plans of asylums lithographed and circulated among the members.

It was also resolved that the annual subscription of one guinea be regularly applied for, and the list of subscribers and their subscriptions be annually published. Another resolution which will be of interest to mention is that Dr. Williams, of Gloucester, was appointed joint Secretary with Dr. Hitch. Mr. Gaskell read a paper "On the Construction of Lunatic Asylums," advocating great separation and detachment of buildings in lieu of having one large and continuous structure, and the meeting adjourned to the following day.

At the adjourned meeting, June 24th, 1847, held at the County Asylum at Littlemore, there were present: Mr. Ley (in the chair), Dr. Corsellis, Mr. Gaskell, Dr. Hitch, Dr. Oliver, Dr. Stewart, Dr. Williams, Dr. Wintle, Mr. Mallam. Visitors: Dr. Giles and Mr. Corsellis. The minutes of the previous meeting were read and a vote of thanks passed to the Governors of the Warneford Asylum for receiving the members of the Association on the previous day. Dr. Stewart was requested to act as Secretary for Ireland. It was at this meeting that the idea of publishing a Journal was first entertained, and the following resolution was passed: "That it is desirable that this Association should issue from time to time, as it shall hereafter be determined, a 'Volume of Contributions relative to Insanity in particular, and to Psychology in general,' " and Mr. Gaskell, Dr. Thurnam, Dr. Wintle, and the Secretaries were appointed to carry it out. The proceedings of this meeting were also ordered to be printed and circulated. Mr. Ley and the Visitors of the

Littlemore Asylum were thanked, and also Dr. Hitch for his continued "invaluable services."

There are no available records now until the year 1849, when Mr. Gaskell having been appointed a Commissioner in Lunacy, a circular was issued to the members, signed by Dr. Hitch and Dr. Williams as joint Secretaries, and Dr. Stewart as Honorary Secretary for Ireland, enclosing a form of letter of congratulation to Mr. Gaskell on his appointment. This is duly recorded and signed by 31 members, which we may take it fairly represents the number of the members of the Association at that date. Here we find for the first time the names of J. C. Bucknill, Superintendent of the Devon Asylum; D. T. Tyreman, Cornwall Asylum; James Wilkes, Stafford Asylum. Mr. Gaskell's reply is also given.

The next entry is a letter, dated March 31st, 1851, in the form of a circular to members, suggesting a meeting in London, signed by the three Secretaries. The majority of the members having decided in the affirmative, a meeting was duly summoned, and on July 17th, 1851, the sixth Annual Meeting was held at the Freemasons' Tavern, London, the following members being present:—Dr. J. Conolly (Hanwell), Dr. Lloyd Williams (Denbigh), Dr. Kirkman (Suffolk), Dr. Nesbitt (Northampton), Dr. Bucknill (Devon), Dr. Begby (Middlesex), Dr. Diamond (Surrey), Dr. Ramsey (Gloucester), Dr. Stewart (Belfast), Dr. Boyd (Somerset), Mr. Prosser (Leicester), Mr. Alderson (Nottingham), Dr. Stewart Allen (Marylebone), Mr. Ley (Littlemore), Dr. Wintle (Warneford), Mr. Eccleston (Rainhill), Dr. Forbes Winslow (Hammersmith), Dr. Henry Munroe (Mayfair), Dr. Wm. Conolly (Hayes Park), Mr. Cornwall (Fairford), Mr. Mallam (Hootmorten), Dr. Bush (Sandywell Park), Mr. Ogilive (Bristol), Dr. Bascombe (Wyke House), Dr. Cox (Fishponds). Dr. John Conolly was requested to take the chair. Neither of the joint Secretaries being present, Dr. Stewart was appointed to act in their place. A letter was read from Dr. Hitch resigning the post of Secretary. His resignation was accepted, a vote of thanks being unanimously accorded to him for his long continued and valuable services (extending over a period of ten years), and at the same it was resolved that he should be requested to continue his services as Treasurer of the Association.

The Committee appointed June 23rd, 1847, reported that the exchange of reports between English and American Asylums was in a great many instances carried on direct, so

that their services were not needed. No additional plans had been received. That their attempt to collect contributions from the members for the purpose of forming a volume for publication had entirely failed, no replies having been received. Consequently the Committee had not met, no subscriptions had been asked, as none were needed, the Treasurer having sufficient funds in hand to defray current expenses. Dr. Conolly, the chairman, advocated the revision of the Lunacy Acts, and was supported by Dr. Kirkman, Dr. Lloyd Williams, Mr. Ley, Mr. Alderson, and Dr. W. Conolly, and a Committee was appointed to examine the Lunacy Acts and report thereon. The Committee consisted of Dr. J. Conolly, Dr. Forbes Winslow, Dr. Bucknill, Dr. Hitch, Dr. Nesbitt, Dr. Boyd, Dr. Corsellis, Dr. Diamond. Dr. Forbes Winslow was appointed Secretary.

The Chairman read a letter from Dr. Williams, of Gloucester, advocating the erection of a Central Criminal Asylum. This was supported by Dr. Begby, Dr. Stewart, Dr. Forbes Winslow, Dr. Kirkman, Dr. Nesbitt, and Dr. Bucknill; and a petition in favour of it ordered to be drawn up by Dr. Williams and forwarded to the Secretary of State.

The Irish Commissioners in Lunacy having, through Dr. Stewart, presented a copy of their last report containing full particulars of the Dundrum Criminal Asylum, they were thanked for the report, and also for the great improvement they had been instrumental in effecting in the District Asylums for the Insane in Ireland, and in obtaining the sanction of the Government to appoint none but duly qualified and experienced men as Superintendents. Dr. White and Dr. Nugent were elected members of the Association. Now we come to an important resolution bearing upon the place and time of future meetings. It was resolved that the Annual Meeting of the Association be in future held in London, on the second Saturday in July in each year, at the Freemasons' Tavern, at one o'clock p.m. That Quarterly Meetings of such members of the Association as can conveniently attend them be held on the first Saturday in the months of March, June, September, and December in each year, at three o'clock p.m. That Dr. Diamond, of the Surrey Asylum, be appointed to act as Metropolitan Secretary. That Dr. Williams, of Gloucester, continue as (General) Secretary, and that the annual subscription be five shillings. Mr. Alderson, of Nottingham, exhibited an im-

proved lock button. All the gentlemen present (who were not already members) were voted members of the Association, as well as fourteen others. The meeting then adjourned to the following day.

The adjourned meeting was held July 18th, 1851, at Colney Hatch, the new Hospital for the Insane for Middlesex. Fifteen members were present, and Mr. Nunnely, F.R.C.S., of Leeds, as a visitor. Drs. Hood and Davey conducted the members over the building. Dr. Hood hospitably entertained them, and the meeting again adjourned. In the evening the members of the Association were received by Dr. Forbes Winslow at a conversazione at his residence, Sussex House, Hammersmith, a large number of members and others being present.

The further adjourned meeting, on July 19th, 1851, was held at the Asylum for Idiots, Park House, Highgate. Six members were present, including Dr. Maxwell, who conducted the members over the institution and grounds, and again the meeting adjourned to the Surrey Asylum, Wandsworth, when nine members were present. Dr. Diamond and Mr. Snape conducted the members through the establishment, and the meeting adjourned to Bethlem Hospital, where they were conducted over the institution by Dr. Munroe, Visiting Physician, and Dr. Wood, Resident Medical Officer. The accounts of the Association are here entered on the minutes; they extend from 1847 to 1851 inclusive, and the expenditure amounted to £17 14s. 11d. This was met by a subscription of 5s. from 20 members, 21s. from Mr. Holland, and the balance in the hands of the treasurer, to whom was still owing 17s. 8d.

July 10th, 1852.—This, the seventh Annual Meeting, was called to meet at the Freemasons' Tavern, London, and the following account of it is given in the minute book:—"Present (only), Dr. Diamond, Metropolitan Secretary. A letter was read from Dr. Williams, the Honorary General Secretary, who, anticipating a limited attendance of members, suggested an adjournment to Oxford on July 21st, at which time and place 'The Provincial and Surgical Association' were to hold their annual meeting. Adjourned accordingly and the same duly announced in the daily *Times*, *Lancet*, and *Medical Times*."

July 21st, 1852.—We now come to the most important of all the meetings of the Association yet held, viz., the adjourned meeting held at Oxford on this date. It was greatly owing

to the zealous and hearty co-operation of Mr. Ley, the Medical Superintendent of the Littlemore Asylum, that this meeting was so successful. It marked an epoch in the history of the Association, characterised by vigour and ability on the part of the executive and enthusiastic support on the part of the members. I need no apology for giving the whole verbatim, for they have never yet been published; they are the last of the unpublished records of the Association, the proceedings of every subsequent meeting having been duly published in the *Asylum Journal* and the *Journal of Mental Science*.

“Oxford, July 21st, 1852.—Adjourned Annual Meeting. Present: Dr. Conolly, Dr. Davy, Dr. Hitchman, Wm. Ley, Esq., — Rice, Esq., Dr. Bucknill, Dr. Wood, Dr. Wintle, Caleb Williams, Esq., Dr. Thurnam, Dr. Forbes Winslow, Dr. Kirkman, — Metcalfe, Esq., Dr. W. W. Williams (Honorary Secretary), Dr. Diamond (Metropolitan Secretary).

“Resolved, on the motion of Dr. Kirkman, seconded by Dr. Thurnam, that Dr. Wintle, of the Warneford Hospital for the Insane, do take the chair.

“The minutes of the last meeting were read.

“Letters were read by the Honorary Secretary from Dr. Ogle (Regius Professor of Medicine in the University of Oxford), Samuel Gaskell, Esq. (Commissioner in Lunacy), and from the following members: Drs. Lloyd Williams, Oliver, Fergusson, Huxley, Allen, Nesbitt, Boyd, Begby, Lockhart Robertson, Messrs. Eccleston, Sandon, Dixon Marshall, Kitching, and from Dr. Stewart (Honorary Secretary for Ireland), all concurring in the objects of the meeting and regretting their inability to attend.

“Resolved, on the motion of Dr. Thurnam, seconded by Dr. Conolly, that Samuel Gaskell, Esq., be elected an Honorary Member of the Association.

“Resolved, after much discussion, on the motion of Dr. Kirkman, seconded by Mr. Ley, that a return be made to the annual subscription of one guinea, and that no member be liable for any other contribution.

“Mr. Ley ably advocated the establishment of a Journal for the use of the members of the Association, and submitted to the meeting several propositions connected therewith (which will appear in the first number of the Journal). Dr. Bucknill addressed the meeting at considerable length on behalf of Mr. Ley’s propositions, in which he was sup-

ported by Mr. Conolly. An interesting discussion ensued, and it was finally resolved, on the motion of Mr. Ley, seconded by Dr. Thurnam, that the Journal be undertaken and that Dr. Bucknill be appointed the Editor. Resolved, on the motion of Dr. Bucknill, seconded by Dr. Hitchman, that the next Annual Meeting be held at Manchester, and that Messrs. Broadhurst, Holland, and Eccleston be requested to act with the Chairman and Honorary Secretaries in making the necessary arrangements. Resolved that the best thanks of the meeting be presented to Dr. Wintle for his able conduct in the chair. The members were subsequently very hospitably entertained by Mr. Ley.—Signed, A. J. Sutherland.”

The contemplated meeting at Manchester was never held, but the reason for deferring it does not appear, and the next entry in the minute book is that of the eighth Annual Meeting, held at the Freemasons' Tavern, London, June 22nd, 1854. This was fully reported in the first volume of the *Asylum Journal* and is the first published record of the Association meetings.

It was at this meeting a resolution was passed making the chairman at the Annual Meeting the President for the year. It also marked the close of Dr. Hitch's long term of official service in the cause of the Association. He had been Secretary since its foundation, nay, more, he was one of the most active of the small band of founders who met at Gloucester Asylum in 1841, and for a period of ten years had been the backbone of the Association. The Association on more than one occasion recorded their appreciation of his invaluable services, and when he resigned the joint Secretaryship in 1851 he was prevailed upon to remain Treasurer. He was well known and greatly appreciated by the late Dr. Hack Tuke, who referred to him at the Jubilee Meeting in 1891 as “our worthy progenitor.” Sir J. C. Bucknill tells me that he knew Dr. Hitch “as an able, busy, bustling, intelligent man. In stature he was small, and he had red hair.” The resolution accepting his resignation, moved by Dr. Thurnam, and seconded by Dr. Kirkman, was “That in accepting Dr. Hitch's resignation the best thanks of the Association are due to him for his great services in the establishment and support of the Association and in the discharge of his duties as Treasurer.”

Dr. Hitch was succeeded in the office of Treasurer by another equally zealous supporter of the Association, Mr.

Ley, of Littlemore Asylum. It was mainly due to his exertions that the Association was kept together, and it was through his action that the Association held the adjourned meeting at Oxford, when he entertained the members most hospitably, and so forcibly advocated the founding of the *Asylum Journal*, with Dr. Bucknill as the first editor. Ever since the foundation of the Journal, so vigorously and so ably edited by Dr. Bucknill, the Association has prospered.

In speaking to me about Mr. Ley, Sir J. C. Bucknill said—"Mr. Ley was a most kindly man, and well known in Oxford, where his brother was master of one of the colleges. Mr. Ley was known to me intimately and well. He was one of the most indefatigable workers the Association ever had, and I should be deeply pained if any record of our earlier days should be published without giving to Mr. Ley the fullest praise for the disinterested manner in which he worked for the good of the Association." In the obituary notice of his death, published in the Journal for April, 1869, it is said :—"Few Superintendents have left a kindlier remembrance on the minds of all than has Mr. Ley. A modest, unobtrusive man, he performed with scrupulous diligence his daily work, he was beloved by all who knew him, and probably no man holding a difficult public office made fewer enemies."

It is to the work of such men as these that the now large and influential Medico-Psychological Association owes its success. Much has been done in the past, and more is to be done in the future to keep up to the highest possible standard the efficiency and usefulness of the *Journal of Mental Science*, which will be 43 years of age on the 15th of November next.

The limits of time and space reluctantly compel me to bring this record to a close. If I have succeeded in establishing clearly that Drs. Shute, Hitch, Thurnam, and Wintle, and Messrs. Gaskell and Powell were our founders, and have aroused interest in the minds of the members of the Association, I shall be well satisfied with the result.

Rest and Exercise in the Treatment of Nervous and Mental Diseases. By Professor L. MEYER, M.D., University of Göttingen.

More than a generation ago (in 1860), in Hamburg, I made my first experiment in treating patients suffering from recent insanity, especially the excited, in bed. This treatment, continued in the Göttingen Asylum, forms a prominent part of my system. It may therefore be inferred that the first experiments were confirmed by many excellent results; while, on the other hand, there have not been wanting occasional failures, which, indeed, attend on every method of medical treatment. I am glad to have an opportunity of laying my experience in this matter before the Medico-Psychological Association. My contribution may be taken as a small tribute in recognition of all I have learned from Great Britain throughout my psychiatric career, both in theory and practice.

A fortunate chance decreed that, from the very beginning of my work as an asylum physician, I was in a position to observe the influence of systematic muscular exercise on the insane. The celebrated Chief Physician of the Department for Mental Diseases of the Charité at Berlin, Professor Ideler, had been in his youth, as was usual amongst cultured gentlemen after the War of Freedom (1813-14), an enthusiastic gymnast, and he had a great admiration for the ancient Greeks who had won for themselves mental and physical health (*mens sana in corpore sano*). It happened, too, that the Senior Assistant Medical Officer was a teacher in the Central Gymnastic Institute, while I, the Second Assistant, was also a fair gymnast. A great number of the male patients, a large proportion of them recently insane, eagerly joined in the exercises; in short, all went excellently and received recognition from the highest authorities (Kultus-Ministry). This was, however, the only result, as we soon discovered, so the matter was allowed to drop.

If one wishes to form an impartial opinion as to the complicated effect of such influences as rest and activity on the diseased organism, it would be well, in the first place, to study as widely as possible the conditions of mental activity during laborious muscular work under normal conditions. An allusion to the experience of the working classes will here suffice, any further discussion seeming superfluous. The

Socialists have universally inscribed upon their banners the shortening of the hours of labour, and preach without ceasing that continual bodily exertion has stupefied the people; that their degradation in every direction is but the expression of their mental inferiority.

The conditions of life among the educated classes are much more noteworthy; their life work consists of continuous and often exhausting mental labour. To observe the effect of the physical exertions which they impose on themselves is not difficult, and answers our purpose well.

I have lived for nearly thirty years in a German University which numbers about 120 teachers and 900 students. I am personally acquainted with a large number of the former, and my position and profession have led me to investigate the conditions of their health, especially the nervous and psychiatric, as fully as possible. The small number of inhabitants of the town (22,000) and other circumstances have made this an easy task.

The University Professors are, as a rule, undoubtedly not given to much muscular exercise. Although they do not carry their avoidance of it so far as to "confine themselves to stall fodder," yet they usually content themselves with a moderate daily walk, a "constitutional." Longer walks may be taken on summer evening excursions, and during the long vacation, but no systematic muscular exercise. Sporting or Alpine expeditions are only undertaken by the younger and more active members of our Republic of learning. It can be proved that maladies interfering with exhausting professional work seldom occur, that the average length of life is very satisfactory, and one must suppose that our learned men, *sine studio*, have found the right proportion between mental and physical exertion. Exceptions are, of course, not wanting, but in this case all exceptions prove the rule. The few University teachers known to me who take systematic physical exercise are without exception nervous; whether *post hoc* or *propter hoc* may be a matter for discussion, at any rate a *circulus vitiosus*. I shall give two examples of this. A Professor, very eminent in his own line, and at my own age of sixty still a very strong man, was an ardent rider and hunter. Immediately after the greatest mental exertions, which were often physical as well, he sought recuperation in the saddle or in shooting. But his object in this, the improvement or cure of his nervous disorders, was not attained; for many years he has

not slept for more than four, or at most five hours at night; he is irritable, changeable in his moods, and has often difficulty in controlling himself, even in unimportant discussions. A younger colleague, who seeks refreshment in long rides on his bicycle, is hypochondriacal in a high degree, and often suffers from a feeling of pressure on the head, backache, etc.

Examples from the opposite standpoint (*e contrario*) have often been furnished by the students going through their one year's military training here. The physical exertion demanded from them is as a rule not too great, and they have time enough to refresh themselves with recreation and plenty of sleep. They seem to be quite well in this mode of life, and look fresh and firm. But on the other hand the case of those who wish to leave off their studies, and are unable to do so, is pitiable. It does not matter if they are only physically affected, and do not complain of any ailment except a constant feeling of fatigue. The sleep of young and vigorous men is remarkably deep, and lasts as long as permitted by duty. But if, as is usual after over exertion, sleep is not so deep owing to vivid dreams, and if the digestion also suffers, further nervous disorders soon follow, such as palpitation of the heart, a feeling of oppression, of pressure on the head, fits of giddiness, etc. When consulted, I have prescribed absolute mental and physical rest in bed, with good nourishing food and plenty of wine. Improvement has always been remarkably rapid; and of course care has been taken that the candle should not again be burnt at both ends.

That the attempt to counteract the consequences of great mental exertion by physical exercise may, under some circumstances, pass the threshold of mental health into the domain of mental derangement, can be proved by an example of considerable practical importance. A professor, well known to me, one of the highest authorities in his own science, a somewhat corpulent man of about 40 years of age, had been working exceedingly hard to finish a great work, which, since then, has passed into a fifth edition. Towards the completion of his task he felt that he was overworked, but no delay seemed possible. When at last he was able to rest considerable derangement had already occurred—distaste for food, palpitation, a feeling of pressure on the head, above all he suffered from almost total want of sleep. Of his own accord, and also by advice of

his doctor, he took long walks in the open air, and extended them further and further as the wished-for result was not obtained. His malady was rather confirmed than otherwise. Sometimes he had sudden fits of alarm, in which, to use his own words, he wandered about "almost dazed for hours together;" he frequently felt giddy, as if he must fall to the ground. At last it seemed to him that those he met, even his friends, looked at him strangely, as if they thought him mad, some pitying, others maliciously triumphant. At times he believed that they had called something after him. At last he thought himself insane, and came to me begging for help and advice. He had run almost all the way from his own house, two miles away, and was quite out of breath and covered with perspiration. He seemed quite exhausted, and changed colour quickly from red to white. His pulse was very small and frequent, his hands trembled, his face wore an anxious expression, and he spoke with difficulty, often stopping, with deep sighs. I gave him a glass of brandy, and he was then able to relate to me the facts of his illness, frequently interrupting himself with such exclamations as: "I am going mad!" "The rascals!" "It is not possible!" There was no fever.

When taken home again, in spite of all protestations he was put to bed, and was kept there for a week. This was accomplished without difficulty, as the patient found the benefit of absolute rest. Very soon he got a sufficient amount of sleep. In this connection I may remark that, when nervous people suffer from lack of sleep, I have always advised complete rest, in the horizontal position, for some hours before the time for going to sleep, generally with good results. The next week my patient remained in bed till the afternoon. Thus, within a fortnight, he might be considered practically cured, and as the season of the year (spring) was not suited for the seaside, he went to the Hydropathic Institute of a medical friend of his. In spite of my advice, he was induced to undergo hydropathic treatment, which had such an unfavourable effect upon him that he gave it up. Many years have elapsed since then without any recurrence of these alarming symptoms. Any mention of other treatment has been intentionally omitted, as no active medicines were employed. The result was, in my opinion, solely due to the rest in bed; for it may be said, with Dr. Batty Tuke, "Stress ought to be laid on the rapidity of cure." In a great number of cases of fully-developed

mental disease of some standing, with fits of alarm, hallucinations, maniacal excitement, etc., I have seen the symptoms yield to rest for one or two weeks in bed, whereas in other circumstances a much longer time would certainly have been required.

If Dr. Clouston objects to the routine which, according to his statement, is dominant in various asylums, and which insures that every insane person remains for a longer or shorter time in bed, he may be assured that his opinion differs from that most widely approved. A doctor for the insane must, in the first place, be individual in his treatment. We have to deal with individuals, individuals differently constituted from each other, individuals who are insane, and I endorse the emphatic assertion of Dr. Savage: "My feeling most strongly is that there is no such thing as insanity, but there are insane people."

If anything is to determine the treatment of the insane (as indeed that of any other sick person), it is the physical state of the person. Psychological appearances have never sufficed to form my judgment. The state of nourishment, the patient's looks, the firmness or flaccidity of the muscles, above all the activity of the heart, the general expression of the face, have always been to me the most important indications of the course of treatment to be pursued. Recognising these, I cannot doubt that the majority of recent cases of insanity, and the essentially similar chronic cases in the recrudescence of their malady, require rest in bed. "The patient is a hospital case, and must be treated on hospital principles" (Dr. Batty Tuke). How often have I told students during clinical instruction that no physician would allow such patients to go about if they did not happen to be insane!

It is certainly generally the custom to put a newly-admitted patient to bed immediately after having had a bath, that he may undergo a strict medical examination in every direction. The determination of the so-called *Status* may easily be deferred for some days, and it has never been observed that this has done the slightest harm. In most cases the patient receives the impression that he is in a hospital, and is regarded and treated by those around him as physically ill. It sometimes happens that they wish to leave their beds, in the belief that they are not ill, but I have much oftener been told by patients that the treatment has had a soothing effect on their feelings and ideas.

The reasons which induced me to leave the patients in bed have already been explained. Very often amongst violently excited patients, or I may say especially amongst them, I have found trembling of the outstretched and extended tongue, and similar muscular twitchings of the face and of the extremities, the signs of considerable motor weakness. The first cardiac sound was often indistinct, muffled, or even reduplicated, the second accentuated. Along with this were intercurrent palpitations, the pulse was proportionately weak, generally frequent, irregular, sometimes intermitting. The arteries were in an atonic state, yielding very easily to the pressure of the finger, and in exceptional cases feeling like cords. The pulse was in this last event small, sometimes disappearing and thread-like. The respiration was similarly irregular, almost always hurried and difficult to count. Sometimes the diaphragmatic breathing was scarcely perceptible; the action was weak, interrupted by a few deep, sighing inspirations. No one will contradict the assertion that these are the signs of an exhausted and irritable nervous system. No practical man would fail to order absolute rest in bed so long as these appearances last. But I have never supposed that morbid expressions of fear or other feelings, delusive ideas, hallucinations and psychiatric aberrations form a counter-indication. I have, however, often remarked that fits of fear are calmed and motor excitement lessened. I have, therefore, ordered rest in bed for some time when these symptoms exist, even though noteworthy indications for it are wanting, and generally with good effect. The duration of the rest in bed must be regulated according to the duration of the symptoms to be combatted. I may, however, remark that it is limited in so far as possible, although it may last for a week or two. Thereafter the patients may pass the morning hours, always the worst for the nervous, in bed; the afternoons are spent in the common sitting-room till evening, or, if weather permits, out of doors.

I have every reason to be satisfied with the results of this course of treatment. Assistant Medical Officers who have come to me from other asylums have always been surprised at the immediate good effect on the mind of the patient, and hence have been apt to go too far in their zeal in this direction. Quite an impartial verdict in favour of this treatment has been given by many of the patients who were in a position

to judge for themselves of the beneficial effects. Their approval is shown in such unmistakable form as to deserve this mention at the close of my remarks.

There are in our institution, as in others where all kinds of insane persons are received, chronic cases with comparatively rare outbreaks of maniacal excitement. In the intervals they scarcely require supervision, and might be allowed full liberty of action, were it not for these outbreaks, which can seldom be foreseen. Many of these patients in the Göttingen Asylum voluntarily go to bed at once on the first symptoms of an outbreak, and only get up again when it is over. They can almost always be relied upon to do this, and I have sometimes been told by a patient who seemed perfectly restored to quietness, and whom I had recommended to leave his bed, that this was not yet advisable.

A Study of Forty-four cases of Fever occurring in the Insane.

By J. KEAY, M.D., F.R.C.P.E., District Asylum, Inverness.

A case of Acute Mania.—Scarlet Fever.—Recovery.

F. M., a domestic servant, aged 20 years, was received into the Inverness Asylum on 13th June, 1894, suffering from acute mania of about a fortnight's duration. There was no assigned cause for the attack, nor was a hereditary tendency to mental or nervous disease admitted.

On admission the patient's physical condition was found in every respect good. Mentally she was in a state of exaltation. She was excited, restless and incoherent; laughed in a wild and silly manner, without cause, rushed about from place to place, was sleepless at night, and, in fact, presented all the usual symptoms of a case of acute mania.

A month after admission the excitement had somewhat abated, but she was still restless, silly, and slightly erotic; would not occupy herself, and was untidy and careless in habits.

In August no improvement in her condition had taken place. An attempt to get her to work in the laundry was unsuccessful, and she had to be returned to the ward.

In September it is reported that she does absolutely no work, and remains in the same unsatisfactory state.

In October it is stated that she amuses herself by running about the ward in a silly manner, talks nonsense, laughs without cause, is untidy and careless in her habits, spits on the floor or table, cannot be got to occupy herself, and is not in any respect improving.

On 10th November she was in bed with a sore throat, and a temperature of 102° , and next day the greater part of her body was covered with a well-marked scarlet fever rash. There was nothing worthy of special remark about the attack of fever; it was a pretty severe one, accompanied by a bad throat and followed by albuminuria which persisted for a considerable time.

With regard to the mental condition, however, the interesting fact is that from the time that the patient was fairly down with the fever, she appeared to have recovered her sanity. She became at once quiet, obedient, sensible in conversation, and tidy in habits. There was not the slightest trouble in nursing her, and as soon as she was allowed to sit up in bed she occupied herself in reading and knitting. When she was allowed to mix with the other patients she requested permission to work in the kitchen with the view of qualifying herself for a better situation than she had filled before her illness. On account of the kidney weakness kitchen work was not permitted, and her discharge was delayed, but at length the albuminuria disappeared, and on February 14th, 1895, she left the asylum sound and well in body and mind.

The sudden recovery of this patient, coincident with an attack of scarlet fever, being the first of its kind in my experience, was to me very interesting, and when I found, on looking over some of the annual reports, that a considerable number of cases of fever had from time to time occurred in the asylum, I thought it might be worth while to hunt up in the case books the records of these with the view of ascertaining, if possible, the proportion of cases in which mental improvement coincided with, or followed, a febrile attack.

The result of this inquiry is seen in the tabular statement on pp. 270-271, in which for the sake of brevity I have grouped all the cases, instead of writing a separate account of each. Many cases of erysipelas, dysenteric diarrhoea, influenza, etc., occurred from time to time, sometimes in

well marked epidemics, but the inquiry is limited to typhoid and scarlet fever.

It will be observed that, including the case of F. M., there are notes of 44 cases of scarlet and typhoid fever which have occurred amongst the patients in the asylum since it was opened thirty years ago. Of the 44 cases, 6 were scarlet, and 38 were typhoid. With the exception of two isolated cases of the latter, one in 1880 and the other in 1884, and of the isolated case of the former last year (F. M.), they all occurred in the 13 years 1866-1878, the number of cases in each year being as follows:—

1866	Typhoid	14 cases.	Scarlet	0 cases.
1867	"	4 "	"	0 "
1869	"	1 "	"	3 "
1870	"	1 "	"	0 "
1872	"	2 "	"	1 "
1875	"	3 "	"	0 "
1876	"	5 "	"	0 "
1877	"	2 "	"	1 "
1878	"	4 "	"	0 "
1880	"	1 "	"	0 "
1884	"	1 "	"	0 "
1894	"	0 "	"	1 "
<hr/>			<hr/>	
Typhoid 38 cases.			Scarlet 6 cases.	

Taking first the six cases of scarlet fever we find that they all recovered from the attack. In two of the six no change in the mental condition was noted as having followed the illness. One of these was a case of chronic mania of $2\frac{1}{2}$ years', and the other a case of secondary dementia of 30 years' duration. They are Nos. 1 and 5 of the table. In another case, No. 2 in the table, the attack of fever was followed by slight improvement, which, though not going on to recovery, proved to be permanent, and the patient was ultimately discharged relieved. She was a case of chronic mania of $1\frac{1}{2}$ years' duration. In the remaining three cases very marked improvement took place, leading on to complete recovery. Two of these were cases of chronic mania of 7 years and 5 years respectively, and the third was the case of acute mania (F. M.) reported above. In no case was it observed that mental deterioration followed the fever.

Six Cases of Scarlet Fever and 38 Cases of Typhoid Fever occurring in Inverness District Asylum during the period 1866-1894.

SCARLET FEVER.

No.	Initials.	Date of admission.	Age.	Form of mental disease.	Duration.	Date when attacked by fever.	Complications.	Termination of fever.	Effect on mental condition and other remarks.
1	J. M.	26, vi., '67	24	F. Chronic mania	2½ years	Dec., '69	None	Recov.	No effect observed. Discharged uncovered, October, 1884.
2	C. F.	7, v., '68	20	F. Chronic mania	1½ "	Nov., '69	Bad throat	"	Slight improvement. Discharged relieved, June, 1876.
3	J. F.	1, x., '69	27	F. Chronic mania	7 "	Dec., '69	None	"	Marked improvement. Discharged recovered, March, 1870.
4	A. U.	22, ix., '71	21	F. Chronic melancholia	5 "	March, '72	Bad throat	"	Marked improvement. Discharged recovered, May, 1872.
5	A. McP.	4, ix., '74	59	F. Delusional insanity	30 "	May, '77	Diarrhoea	"	No improvement. Still in asylum. Demented.
6	F. M.	13, vi., '94	20	F. Acute mania	5½ months	Nov., '94	Albuminuria	"	Marked improvement. Discharged recovered, February, 1895.

TYPHOID FEVER.

1	H. R.	21, vii., '66	70	F. Acute melancholia	2 weeks	Aug., '66	None	Recov.	Great improvement. Discharged recovered, December, 1866.
2	E. McL.	28, vi., '64	37	F. Chronic mania	3 years	Aug., '66	None	"	No improvement. Still in asylum. Demented.
3	S. McP.	30, vi., '65	56	F. Dementia	2½ "	Aug., '68	Constipation	Died	Died 5th September, 1866.
4	E. McN.	26, xi., '65	54	F. Dementia	6 "	Sept., '66	Gastritis	"	Died 2nd October, 1866.
5	C. McP.	30, vi., '66	70	F. Acute mania	6 months	Jan., '67	Exhaustion	"	Died 21st January, 1867.
6	J. McL.	19, vii., '64	69	F. Dementia	12 years	Oct., '66	Refusal of food	"	Died 4th November, 1866.
7	J. McL.	7, vii., '64	53	F. Delusional insanity	5 "	Sept., '66	None	Recov.	No improvement. Discharged not recovered, October, 1880.
8	D. M.	14, v., '66	30	F. Dementia	7 "	Sept., '66	Relapses	"	Considerable improvement, but died in asylum of phthisis, 20th July, 1876.
9	K. McM.	15, ix., '66	16	F. Chronic mania	2 "	Oct., '66	Acute delirium	"	Marked improvement. Discharged recovered, March, 1867.
10	A. McK.	25, v., '66	40	F. Chronic mania	3 "	Nov., '66	None	"	Slight improvement. Discharged uncovered, May, 1878.
11	K. K.	24, vi., '65	24	F. Chronic mania	2 "	Oct., '66	None	"	No improvement. Died of pneumonia, December, 1870.
12	B. McR.	2, vii., '64	46	F. Dementia	7 "	April, '67	None	"	No improvement. Died of tuberculosis, May, 1877.
13	L. C.	28, xi., '64	67	F. Dementia	20 "	Nov., '66	Relapses	"	No improvement. Died in asylum of old age and exhaustion, February, 1874.
14	A. McK.	17, xi., '65	34	F. Dementia	4 "	Feb., '67	Menorrhagia. Exhaustion.	Died	Died 7th March, 1867.

No.	A. I.	2, vii., '63	35	F.	Chronic melancholia	7 years	Oct., '66	3	None	Recov.	No improvement. Died 31st August, 1869, of intestinal obstruction and peritonitis.
17	D. McK.	30, vi., '66	49	M.	Delusional insanity	8 months	Oct., '66	4	None	"	No improvement. Discharged unrecovered, January, 1879.
18	W. G.	25, xi., '65	17	M.	Imbecility	From childhood	Dec., '66	8	Relapses	"	No improvement. Died of phthisis, 22nd September, 1869.
19	A. R.	22, xii., '65	32	M.	Dementia	Unknown	March, '69	1 month	Perforation	Died	Died 27th April, 1869.
20	J. McL.	10, iii., '65	41	M.	Delusional insanity	5 years	March, '70	5 weeks	Gastritis	"	Died 5th April, 1870. Had phthisis pulmonalis.
21	D. K.	9, ix., '71	23	M.	Chronic mania	2 "	March, '72	4	None	Recov.	Marked improvement. Discharged recovered, 9th May, 1872.
22	A. R.	8, v., '72	21	M.	Folie circulaire	9 months	July, '72	4	None	Died	Died 4th August, 1872. Had acute phthisis.
23	G. H.	30, xi., '65	46	M.	Delusional insanity	13 years	April, '75	5	Excessive diarrhoea	"	Died 10th May, 1875.
24	C. M.	19, vii., '64	49	M.	Chronic mania	24 "	Jan., '76	10 days	Exhaustion	"	Died 2nd February, 1876. Had acute phthisis. Hamoptysis.
25	S. F.	12, ix., '73	43	M.	Chronic melancholia	3 "	Feb., '76	5 weeks	Pleuro-pneumonia	Recov.	No improvement. Still in asylum. Demented.
26	R. M.	30, vii., '72	31	M.	Imbecility	From childhood	Feb., '76	5	None	"	No improvement. Died of phthisis, 30th June, 1881.
27	J. D.	31, v., '64	*	M.	Dementia	5 years	May, '75	2	Peritonitis	Died	Died 3rd June, 1875. No. 14 is his brother.
28	F. C.	7, v., '74	54	M.	Acute melancholia	1 month	Jan., '76	3 months	Albuminuria	Recov.	Slight improvement. Died in asylum of heart disease, May, 1882.
29	J. M.	25, vi., '75	19	F.	Acute melancholia	5 months	Oct., '75	10 weeks	Relapses	"	Marked improvement. Discharged recovered, February, 1876.
30	C. McL.	25, xi., '76	46	F.	Acute melancholia	1 month	Jan., '77	8	None	"	Slight improvement. Discharged recovered, June, 1883.
31	J. C.	31, x., '64	71	M.	Chronic mania	14 years	March, '77	8	None	"	No improvement. Died October, 1879, of "exhaustion."
32	A. McD.	23, viii., '75	41	F.	Dementia	3 "	Oct., '76	4	None	"	No improvement. Discharged unrecovered, March, 1879.
33	M. McK.	24, v., '77	25	F.	Acute mania	2 weeks	Feb., '78	7	Pneumonia	"	Marked improvement. Discharged recovered, July, 1878.
34	D. M.	28, ix., '78	19	M.	Adolescent mania	6 months	Dec., '78	10	Relapses	"	No improvement. Still in asylum. Demented.
35	J. McG.	15, iii., '65	49	M.	Dementia	13 years	Dec., '78	3	Delirium and exhaustion	Died	Died 28th December, 1878.
36	W. McA.	13, xii., '77	40	M.	General paralysis	2½ months	May, '78	8	Pneumonia and acute delirium	Recov.	Marked improvement. Discharged on probation, September, 1878, and recovered 18th January, 1879.
37	D. McD.	10, ii., '75	20	M.	Imbecility	From childhood	Feb., '80	4	Exhaustion from excessive diarrhoea	Died	Died 9th March, 1880.
38	D. T.	9, iii., '77	47	M.	Epileptic mania	1 month	Oct., '84	11 days	Epilepsy and exhaustion	"	Died 17th October, 1884

* Unknown.

Taking, then, the 38 cases of typhoid, we find that 23 recovered from the attack of fever, and no fewer than 15 died. With regard to this very high mortality, it may, however, be observed that while it is certain that all the deaths from typhoid which have taken place are included, being taken from the Register of Deaths, it is not improbable that some cases of the fever in which death did not occur may have been overlooked in the examination of the case books, and some, perhaps, have not been entered there at all.

Of the 23 cases in which recovery from the fever took place, six are reported as having derived benefit to the mental state therefrom, and were discharged recovered shortly afterwards; three improved, but did not recover; and 14 appeared to be quite unaffected. Of the six cases in which recovery took place it is important to notice that three were recent and acute curable cases of mania and melancholia, in which recovery would probably have taken place in any event. They are Nos. 1, 29, and 33 in the tabular statement. The fourth and fifth cases in which recovery took place were chronic maniacs of two years' duration, Nos. 9 and 21 of the Table. With reference to one of these cases, No. 21, Dr. Aitken remarks,* "His state of excitement had previously resisted all treatment." He steadily improved after the febrile attack, and was discharged recovered in five months. The sixth case, No. 36, deserves a word or two, and I cannot do better than quote from Dr. Aitken's own report. He says †:—"In December, 1877, a male was admitted in a state of considerable excitement, his violence, his habits of wandering during the night, and his probable tendency to suicide having absolutely necessitated his seclusion. At this period there was inequality of the pupils, tremor of the hands, marked *bégaiement*, a dragging of the left leg, and difficulty of picking up objects—all the physical symptoms in fact marking the advent of general paralysis. At the same time there existed the characteristic grandiose and optimistic ideas distinguishing this malady. He did not appreciate his position, took no notice of his surroundings, lavished favours and fortune on his associates, had unlimited credit at his command, looked upon large sums

* "Eighth Annual Report of Inverness District Asylum," p. 15.

† "Fifteenth Annual Report of Inverness District Asylum," p. 19.

with the utmost indifference, daily announced his marriage, was never disappointed when it was put off, took shootings for the season, and negotiated for the purchase of estates which he saw in various papers, and lived in a state of the utmost happiness and self-satisfaction. For nearly six months he continued in this condition, when he experienced a severe attack of typhoid fever, emerging from it by a prolonged convalescence, during which he did not encourage conversation, and spent the time chiefly in the perusal of Dickens's novels. Succeeding this, he passed through a period of slight irritability, confused and perplexed at the position in which he found himself, and, lastly, he entered what appeared to be a condition of perfect sanity." This case of what appears to have been general paralysis was discharged recovered, after a period of four months on trial, on 16th January, 1879, and he has not been returned to the asylum.

In no case of typhoid is it recorded that the mental condition was affected injuriously by the fever.

It would appear to be the case, therefore, if any conclusion can be drawn from the examination of such a small number of cases, that mental improvement does not so often accompany or follow typhoid as it does scarlet fever. More extended observation, perhaps carried out by a method of collective investigation, on the effects produced by different kinds of fever, or febrile disturbance, on mental disease—an attempt to determine in fact the value of the different varieties of fever as therapeutic agents in insanity, would perhaps be productive of useful as well as interesting information.

During the same period in which 43 cases of fever occurred amongst the patients in the asylum I find recorded 23 cases amongst the officials, 19 being typhoid, and 4 scarlet fever. It is not stated that there was any death. Here it may be remarked that other cases of fever may have occurred amongst the sane population of the asylum, of which mention has not been made, but if a member of the staff had died of fever it would certainly have been recorded.

It would appear, then, that sane people are more susceptible to typhoid fever and to scarlet fever than the insane. This was observed by Dr. C. M. Campbell in an epidemic of typhoid which occurred at the Durham County Asylum in 1881, when out of 160 patients and 13 nurses

exposed to infection, 22 patients and 5 nurses were attacked.* The mortality, however, is, as one would expect, higher in the case of the insane.

In epidemics of influenza in asylums, it has been observed that the number of sane residents attacked is not seldom out of all proportion to the number of insane. In explanation the reason is given that the sane residents in an asylum, mixing more with the outside world, are more exposed to infection. In the case of typhoid, in which the source of infection lies within the asylum itself, this reason does not apply. The true reason probably is, in the case of influenza as well as other infectious fevers, that the sane are attacked more rapidly and in greater proportion because they are more susceptible to such diseases than the insane.

The fact has long been recognised that improvement or recovery from mental disease not uncommonly coincides with, or follows, a fever or other physical disorder. From time to time isolated cases have been published, and the subject is referred to in some of the text-books on insanity. Bucknill and Tuke,† for instance, refer to the cure by fever of cases hopelessly demented, and Clouston‡ predicts treatment by the inoculation of some substance producing a manageable fever. The subject is also briefly referred to by Griesinger§ and Ball.|| The best account we have of the effect of typhoid upon insanity is that by Dr. C. M. Campbell in Tuke's *Dictionary of Psychological Medicine*,¶ and in the *Journal of Mental Science* for July, 1882, where he published a report of the 22 cases already referred to as having occurred at the Durham Asylum. In the same *Journal*, for 1863, is an exhaustive account by Dr. W. C. McIntosh, now Professor McIntosh, of St. Andrew's, of an epidemic which occurred in the Perth Royal Asylum; and in the number for April, 1887, is a report by Dr. Percy Smith on six cases at Bethlem Hospital in 1885 and 1886. Epidemics of scarlet fever in asylums are of rarer occurrence, and I find no record of such.

Why an attack of fever should bring about improvement, or recovery, in the case of say a chronic maniac, and how it

* "Journal of Mental Science," Vol. xxviii., p. 212.

† "Psychological Medicine," p. 192.

‡ "Lectures on Mental Diseases," p. 135.

§ "Mental Pathology and Therapeutics," p. 291.

|| "Leçons sur les Maladies Mentales," p. 432.

¶ Vol. i., p. 506.

is brought about are questions to which a satisfactory answer cannot be given. Bucknill and Tuke * suggest that it is by causing a state of "feverish excitement" of the brain: Clouston† that it is by producing an alterative effect, and so stimulating nutrition: C. M. Campbell‡ that the curative effect "may be more correctly credited in part to the favourable influence of extra attention, and to the stimulating consciousness of serious illness and of specialised surroundings and treatment." None of Professor McIntosh's cases were permanently benefited mentally by the feverish condition, and he suggests § that "the relief of the mental on a supervention of a physical ailment, seems as yet to be a coincidence."

It will be seen, therefore, that the subject is one about which there is much uncertainty and doubt. Fresh interest has recently been added to it by the results obtained by Drs. Bruce and Macphail in the treatment of cases of insanity by the administration of thyroid gland. In this treatment a condition of fever is deliberately induced, and appears to be an essential, if not the essential, part of it. The thyroid treatment of insanity is only a step in the right direction. Its weak point is that the fever produced is not sufficiently acute, and what is required is an agent under control which will produce a condition of pyrexia something like what we have in scarlet fever.

The Systematic Employment and Training of the Insane.|| By EDWARD D. O'NEILL, M.R.C.P.I., Medical Superintendent, District Asylum, Limerick.

The subject-matter of this paper is one that I have always taken a great interest in since my connection with psychology, believing it to be the key-stone to modern treatment of the insane, and a valuable adjunct in setting a good example to a class of people who are prone to do evil as the result of their mental aberration, or the tendency to do nothing, or from want of something to do. It is a truism that work is a powerful antidote to low spirits, and if we contrast the asylum treatment of to-day with that of years ago, how strange and startling is the effect!

* P. 192.

† "Lectures," p. 135.

‡ "Tuke's Dictionary," Vol. i., p. 507.

§ "Journal of Mental Science," Vol. ix., p. 36.

|| Read at the Irish Divisional Meeting held at Limerick, October, 1895.

One of my predecessors, in his annual report for the year 1858, mentions that he was informed by a nobleman, who was visiting the institution, that he recollected when lunatics were buried up to their necks in the earth in order to keep them quiet and prevent them from giving trouble. Is it any wonder then that asylums were looked on with so much dread and horror when the strait-jacket, manacles, and dark, padded rooms (with rings in the walls to attach the unfortunate patients to) were called into daily requisition? Owing to the enlightenment of the age, and the modern non-restraint treatment adopted in asylums, they are not so much dreaded as formerly; but are rather looked upon as hospitals for the treatment of the insane, and this is the appellation by which they should be designated, and not by the primitive term by which they are at present known, as the name "lunatic asylum" is too suggestive of one of the most painful and distressing maladies that flesh is heir to. In this respect our friends across the Atlantic are more in touch with the times.

The question of employment for the insane is a most important one, and, in my opinion, it is the safety valve that prevents many explosions of maniacal excitement and fits of melancholic depression. Moreover, it is indubitably the chief power in regulating the routine machinery of asylum administration.

In every asylum with a skilled and efficient staff of tradesmen-attendants, I hold that all works in connection with the institution should be executed by house labour, except those of a very heavy nature or attended with risks, as in the case of high buildings. With a competent staff the work can be done quite as satisfactorily as if carried out under contract, and every Superintendent with practical knowledge must admit this.

A divergence of opinion exists regarding the duties of Superintendents. It may be argued that it is not a part of a Superintendent's duties to bother about bricks and mortar or tradesmen generally, but that he should confine himself to the purely medical portion of his work. In any case, I think it will be conceded that his time would be more profitably engaged looking after the material comforts of his patients, than in having to spend hours at clerical work in examining and vouching bread and butter accounts.

To illustrate my views of what can be done by house labour, I will take this hospital as an example. The entire

work of the institution, including all branches of industry—masonry, carpentry, plastering, slating, painting, engineering, baking, tailoring, shoemaking, upholstering, and smith work—is executed by the staff, assisted by the patients.

Every article of patients' clothing, male and female, as well as that of the attendants, is made in the house. Every capable patient is induced to do something according to his physical and mental condition. If found not equal to one class of work, he is put to another, until ability or fancy is suited, and he is taught to understand that in steady industry lies his best chance of recovery. Extras as a reward are given, and in a short time he comes to know that his labour is appreciated and that he is gaining ground mentally and bodily. Some of my best workmen are mentally the worst cases in the house, but as regards work and extras are particularly keen, and in the absence of the latter would strike work at once.

I have long thought that if a system of small payment for labour was introduced into our hospitals it would work very beneficially, either as a means of procuring extra comforts or providing the patients with a little means on discharge to make a fresh start with. In the prison service a system of small payment is carried out, and it appears to work very well. Amongst the many tasks set apart for prisoners—labours which would suit a large number of our patients—are those of mat-making and splitting timber for firewood, from the sale of which is derived a considerable sum. Every Superintendent is daily reminded by his patients that they are working for nothing and losing their time, whereas if something on the lines suggested was adopted they would be far more content in the knowledge that they were earning, no matter how small the amount. Another idea worth a trial as an inducement to work would be the introduction of a small well-stocked store for the sale of articles suitable to the patients, such as books, newspapers, tobacco, etc. The store to be in charge of a reliable patient, and the profits derived from the sales to go to the common fund for the payment of the patients in the house or those on discharge. This would be the means of infusing a greater desire for work, and at the same time act as a magnet in attracting much interest in the dull routine of asylum life.*

* [These proposals have been ably advocated by Dr. Mercier in his book on *Asylum Organization and Management*, *q.v.*—ED.]

As a sample of asylum workmanship, I refer with very great pleasure to the male observation department, completed a few years ago under my supervision, consisting of dormitory, corridor (with seven single rooms), bathroom, water-closet, and clothes-room. I have already given particulars of this work in my annual reports, and will not take up your time in describing it, but will have much pleasure in showing you this department later on. In passing, I may mention that during the past five years over one hundred large wooden window frames and sashes have been introduced in lieu of small iron ones.

I think that I have proved conclusively the chief advantages derivable from the system of employment carried out in this asylum.

1st. The benefits conferred on the patients.

2nd. The excellence of the work.

3rd. The saving to the rates.

So far I have only referred to the different trades. I now come to the important question of agricultural labour. Undoubtedly one of the greatest blots in connection with the Irish lunacy administration is the totally inadequate quantity of land attached to our asylums. I am aware that the executive are alive to this serious drawback, the great difficulty being that it is almost impossible to get more land in consequence of the asylums being so closely situated to the different towns or in the immediate proximity of other public buildings. This country, unfortunately, is essentially an agricultural one, with few industries or manufactures to employ and educate skilled labour. The bulk of the people must live by the land. The majority of our patients are labourers, and without the means of employment which is at the same time healthy and what they have been accustomed to; the treatment in an asylum is looked upon merely as a means for their retention and safety and not for ultimate recovery and discharge. With this asylum we have only thirty-five acres of land for our 576 patients, and nearly half of this area is under buildings. Take an English Asylum, for instance, with the same number of patients, and at least five times the quantity of land would be attached to it.

In acquiring additional land Boards of Governors are inclined to look upon the expenditure as costly and unnecessary, forgetting altogether the important fact that the initial expense is the only one, for in the end it would indubitably be for the benefit of the patients and in the interest of the ratepayers, as I am prepared to prove. If we had sufficient

land attached to our hospitals what would be the result? Pure milk, an unlimited supply of vegetables—a most important item in the dietary of the insane—an increased recovery rate, a decreased expenditure, and last, though not least, employment to suit the bulk of our patients.

Another important factor in connection with the employment and training of the insane is an efficient trained staff. A patient, no matter how insane, will after a little time learn to respect an attendant who knows his business, and, moreover, do what he orders him, simply from the tact displayed in the discharge of his duty and the kind manner in which he attends to those under his care. In order to obtain and retain good attendants a more liberal salary, commensurate with their responsibilities, should be given.

Heretofore a course of training for the certificate of the Medico-Psychological Association was a very difficult task to undertake in consequence of the small medical staff in most of our asylums; but now that in nearly all of them there is an Assistant Medical Officer, I have no doubt more attention will be paid to this subject. To encourage the staff to make themselves thoroughly acquainted with their duties and with the Handbook issued by the Association, I suggested to my Board, and it was adopted, that a sum of £12 should be given yearly in money prizes for proficiency. I am very glad to say that the result has amply justified my anticipations.

In connection with the employment of the insane, I must not be taken as advocating labour to any severe or irksome degree, but purely as a remedial agent, and one that, sooner or later, must tend to brighten up and restore dormant faculties. Dr. Clouston, in his admirable discussion on rest and exercise in the treatment of nervous and mental diseases at the last Annual Meeting of the Association, ably advocated the advantages derived from "exercise." From my standpoint I would much prefer the word "employment," as indicating manual labour, and not that of exercise, as merely suggestive of walking about, massage, etc. From a pathological aspect I agree with Dr. Batty Tuke, but from a practical point of view in the administration of an asylum I would far prefer to stand by "exercise" and its admitted advantages, as against "exercise" with its supposed pathological disadvantages.

In conclusion, I daresay exception may be taken to some of the views I have put forward in connection with this subject, but each day's experience convinces me more and more that it is a move in the right direction, and, like every other

innovation, it only requires time and experience to make it workable and appreciable.

I submit a table giving the industrial occupations of patients in the Limerick Asylum on the 22nd October, 1895.

		Males.	Females.
1	Assisting Attendants in the Wards... ..	60	53
2	Farm Labourers... ..	75	—
3	Clerk	1	—
4	Storekeepers	2	—
5	Stokers	6	—
6	Bakers	2	—
7	Tailors	8	—
8	Shoemakers	6	—
9	Upholsterers	14	—
10	Painters	12	—
1	Carpenters	12	—
12	Blacksmith	1	—
13	Plasterer	1	—
14	Stone-cutters	2	—
15	Kitchen	2	3
16	Laundry	—	50
17	Scullery	4	7
18	Needlework	—	60
19	Knitting	—	20
20	Fancy Work	—	9
Total Employed		208	202

Unemployed.		Males.	Females.
Refusing to Work		18	20
Unemployed because of —			
(a) Mental condition		32	29
(b) Bodily condition		28	32
(c) Other causes		3	4
Total unemployed		81	85
Total in Asylum		289	287

Discussion on Dr. O'Neill's Paper.

Dr. WOODS was of opinion that in Ireland at least any work under the supervision of the Superintendent and the asylum staff was far better than that done by contract. They all felt, he said, the importance of employment, and he was sure they all endeavoured to employ every patient possible. Much rested with the attendants, of course, but they were teachable enough. His experience of training his staff was a pleasant one. Three-fourths of the candidates he had sent up for the certificate of the Association had obtained it on excellent answering, and his Board of Governors had generously acknowledged their efforts.

Dr. GELSTON said that, as one of the oldest, if not the oldest, surviving "Visiting Physician" of an Irish Asylum, he was in a position to compare modern methods (as exemplified in Dr. O'Neill's management of the Limerick Asylum) with those in vogue in his own earlier memory. In nothing was the change more remarkable than in this matter of employment. Asylums are now houses of industry. He had seen, now long ago, as many as twelve unfortunate lunatics tied together with an iron chain. In those days there was no such thing as employment for patients, but he had come to see, under Dr. O'Neill and his predecessor, companies of patients employed daily in the gardens, as orderly and tranquil as, and perhaps more industrious than, sane men.

The CHAIRMAN dwelt upon the practical character of Dr. O'Neill's excellent paper. He was anxious to learn from Dr. O'Neill whether he had yet had any trouble from the claims of Trades' Association: artisans refusing to teach or to work with patients who were not "regular workmen" and so forth. The speaker had had some little difficulty in this way, but there had been more in certain English Asylums; and unfortunately the Tradesmen's claims, which worked out so cruelly against the patients, were understood to be not without sympathy among County Councillors. He thought it the duty of Superintendents to insist upon their right to employ any and every patient in any and every way that is to the patient's benefit. Another question was with regard to the employment of women. The occupations that women follow are mostly sedentary, and it is possible that we may overdo the employment of our female patients if we do not see that they get systematic exercise also. Anything is better than loafing and lounging, and the speaker held that systematic exercise (drill, marching, etc.) among those who would not "work," both men and women, was very salutary, and lessened the number of non-workers as well. None of our Irish asylums have sufficient land attached to them to afford either employment or even exercise in a satisfactory way. The Dublin Asylum is a notorious example, with a property of between fifty and sixty acres, including land under buildings, and a population of close upon sixteen hundred patients.

Dr. BAGENAL HARVEY having touched upon some other points, was anxious to know how far it would be possible in town asylums, like Dublin, Limerick, etc., where space was limited and the grounds overlooked, to send out patients to walk with the attendants outside the asylum.

Dr. O'MARA, in reply to the last speaker, said that the Limerick Asylum patients were sent to walk out in the country. The sane population objected, and made representations to the Governors on the subject. The objections were thought to have originated among the patients' friends, who did not care that they should be seen in public.

Dr. NASH had little fear that the staff would not be well taught and efficient where the Superintendent was allowed due power and authority. With regard to the difficulty of providing exercise for women, he thought the Chairman had made more of this than it was worth. What is true of women in asylums is true of women everywhere else. When the speaker was assistant in the Dublin Asylum, biliary and other troubles, such as the Chairman had referred to as consequences of a sedentary life, were, as the latter would remember, not unduly frequent among the women. A large number of the female patients in that institution were sent out to walk in the country or in the parks two or three times a week.

This had been the rule for a great number of years and no trouble arose in consequence.

Dr. O'NEILL said that he had not experienced the trouble about working men, to which Dr. Norman had referred. With regard to the employment of women, he recognised the difficulty which had been referred to, and he endeavoured to cope with it by insisting on outdoor exercise for his needle workers. He regretted that the small size and bad position of the asylum property prevented him from being able to employ a number of his women on farm work. Many of them came from the country and had been used to farm work all their previous lives, and he believed it would be a very wholesome and desirable form of employment for them.

Lunacy Laws in Colorado. By E. HOBHOUSE, M.D. Oxon.,
San Remo.

A short account of the proceedings in a case of lunacy in the State of Colorado may not be without interest and value to the readers of this Journal, as there has been some agitation in England for the establishment of a similar form of procedure. As each State makes its own laws in the matter, they vary in every State of the American Union. In Colorado the procedure for committing a lunatic consists, briefly, in trial by jury before a judge or what we should call in England a stipendiary magistrate, and precisely resembles the proceedings of a criminal trial in England.

As a preliminary, a complaint has to be lodged with the sheriff, generally by a relative or the medical man, to the effect that A. B. is supposed to be a lunatic, and dangerous to the peace of the State of Colorado. With this object, in a case in which I was called in by a fellow practitioner, we went to the house of the patient, a dentist, who was supposed to have recently had an attack of meningitis, from which he had not recovered. He had persistent insomnia, with headache, and believed that he had received a call to give up dentistry and devote his life to converting Indians, as a preparation for which task he spent most of the day and night in singing psalms and reading the Bible.

He was a sorry spectacle, for in order, as he said, to relieve the irritation of his brain, he had applied croton oil freely to his scalp and forehead which were covered with blisters.

He had threatened his wife frequently and was very irritable, but perfectly coherent and rational in his talk, and the only apparent delusion was about this call to missionary work. He had a bad family history, and I was soon satisfied that he was insane, but it did not promise to be a specially

easy task to convince a Colorado jury of that fact. However, the information was duly lodged, and as matters proceed rapidly in Colorado, and the judge was off on a political campaign next day, I received a summons in an hour to attend and give evidence. The judge was swearing in seven good men and true, gathered from the streets and drinking saloons, when I arrived, and after appointing an attorney (also barristers in America) on each side, the proceedings began by summoning the accused, who was brought forward in custody of the Town Marshal. The accused was asked if he knew why he had been brought there, and on his answering yes, the examination and cross-examination of the wife and two physicians by the respective attorneys for the State and the defence was proceeded with. Then the foreman of the jury and one or two jurymen asked some questions, and having elicited from the accused that he was willing to go to the asylum, they quickly returned a verdict that he was insane. Probably the fact that he was a pauper and was running up bills in the town made them the more ready to provide him with subsistence at the expense of the county, which was henceforth charged with his maintenance.

The verdict was a relief to those concerned, as the accused was rather vindictive, and shooting a doctor would be held a venial offence in Colorado. The local paper had an indignant article next morning on the persecution of Dr. L., as it called it, but the patient being then well on his way to the State Asylum, 300 miles off on the other side of the Rocky Mountains, no result followed.

The chief impression which the proceedings made on me, was that it was a very undesirable way of eliciting evidence in cases of lunacy, whatever the advantages of publicity. It is obviously extremely unpleasant for a wife or near relative, as well as for the medical men, to have to give evidence in public, before the person charged, and it may lead to the suppression of important facts. Moreover, the publicity itself, and the quasi-criminal aspect of the whole proceedings, the supposed lunatic being treated as a criminal, can hardly be agreeable and might be very injurious to one who was unstable and excitable. Though the jury in this case returned a right verdict, it did not alter my conviction that such cases are for the most part very ill suited for such a form of procedure, and it is very doubtful what their verdict would have been, had the accused not signified his willingness to go.

Anyone who has once participated in such proceedings feels instinctively that some stigma must almost inevitably attach to one who has thus been placed on his trial, though it is not easy to convey the impression in words; and it is difficult to see what advantages such a system offers over that now in use in England.

Visions: A Personal Narrative of Morbid Phenomena.

[The following communication was sent for publication by a journalist of experience. The mental aberrations described were preliminary to an attack of acute mania, from which the author happily recovered some three years ago.—*Ed.*]

THE HIDDEN MYSTERIES OF NATURE AND OF SCIENCE.

Experiences in the mystical borderland of science have generally so little to commend them to the consideration of practical intellects, and are so often narrated in terms calculated to offend common sense, that I have for some years refrained from giving publicity to this account of the strange impressions on the visual sense which marked a period of some months of physical weakness and nervous tension. And if I now write of these visions it is in the hope that a faithful narrative of the circumstances may lead to sounder views than are now obtaining, and being widely promulgated by certain would-be leaders of thought who, in the Press and on the platform, are confounding this age of materialism by reviving teaching which would disgrace a heathen priesthood, and which outrages our fondest hopes and beliefs.

I have used the word "visions" to express the presentment to the sense of sight of pictures having no material embodiment, and in no single instance did these convey to my mind any other impression than that of views projected by the eye, as by a magic lantern, nor did they appear at all unnatural or alarming, any more than when by an effort of the imagination one calls up at will the picture of a well-remembered place or person.

The wonders of photography have been obtained by following Nature in the construction of the eye, and to me it is not more incredible that "negatives"—for want of a better word—should be retained by the visual organs, than that the record of facts and events, which we call memory, should remain in the hidden chambers of the mind to be

called up at will while health permits, or to run riot or altogether vanish with decaying faculties.

I cannot better describe my mental attitude under these impressions than by saying that throughout I was fully conscious of their being distinct from the actual life around me. If they interrupted action or diverted thought from other matters then engaging attention, it was but for the moment; though this very quietude of mind at these times may have found its reaction in the brief periods of uncontrolled and sometimes unremembered speech that on several occasions supervened. "Brain fever," the doctors said, and I must leave the faculty to determine how far that disorder may account for the phenomena, simply contenting myself with the assurance that at the times to which I am about to refer I was able both to think clearly and act coolly, nor did I feel any of the nervous irritation from which at other times during my illness I suffered so keenly as to be unable to control.

The first occasion on which I experienced what I cannot call a visual deception, since I was not for a moment in doubt as to the unreality of the thing portrayed, was at the close of an ordinary day's business. I was engaged in a handicraft requiring almost constant supervision of the workmen, and in which there was little or no mere routine work. On this particular day I had a business appointment at 6.30, from which I hoped to be at liberty in time for the commencement of a musical performance, which was one of the chief local events of the year. I had booked seats in a good position, and being disappointed in obtaining the company of the friend I had asked to join me, the chair next to mine was vacant. I was tired, and perhaps looked it, but enjoyed the performance, though once or twice the music that I heard seemed out of keeping with the programme to which I referred, expecting to find that a chorus from one of the oratorios had been selected. A considerable number of the orchestra and vocalists were personally known to me, but several times I found my perception of well-known people lost in a sort of idealised crowd, out of which looked faces that belonged to other times and places. Shaking off the tired feeling for the time, I resolved to leave at ten and go straight home to bed. Shortly afterwards an interval occurred in the programme, and while looking round at the occupants of adjacent seats, I glanced at the empty chair by my side and saw thereon the image of a wreath of exquisite

white flowers. The illusion lasted but a few seconds, and I could not then or since recall having recently seen any such floral ornament, or remember any occurrence likely to fix such a fancy in my mind. The only possible suggestion that I could think of was that I had that morning met a florist with whom I was well acquainted. He was entering the railway station as I was quitting it, and was carrying a box, evidently containing flowers. I remembered thinking that it was a wreath from the shape of the box, and the question was in my mind as we nodded a passing salutation.

In that instant, did there pass from eye to eye the picture of the contents of the box? I cannot tell, for apart from that, my mind may have retained the imagery of dozens of such wreaths; but whatever the original, how came its phantom to be selected from the store-room of the eye's stock of negatives?

No, kind cynic, I had not been imbibing. I was just worn out with work and worry, that was all.

Within a week from this, under medical advice, I took a three months' rest from business, only returning to the office when an approaching parliamentary election rendered my presence absolutely necessary, and was fortunately able to see all the most important of my contracts through before I was again compelled to rest from business. This time, my nervous prostration was much greater than on the previous occasion, and such sleep as I got during the succeeding fortnight was of a very fitful nature, and only obtained by the use of bromide of potassium, but it was wonderfully exempt from dreams. Indeed, it appeared that the mental activity, or cerebral excitement, which under ordinary circumstances produces dreams, wore itself out during periods when I was lying, to all intents and purposes, wide awake and fully conscious of my surroundings. This was generally in the early morning.

On one occasion a series of vignette portraits of faces disfigured by disease and malformation formed themselves against the white hangings of the bed. These were circular in form and of the size of the discs which one sees after looking at the sun. I can well remember that it was a favourite amusement of my youthful days to watch such discs rise from the gas lights in the church, and, having started two or three, race them across the white-washed ceiling under the gallery over our pew. To indigestion I afterwards learnt to ascribe this faculty of whiling away the

time during an unappreciated sermon. The last of the vignettes was a three-quarter figure of a lovely woman, beautifully attired. Asked what sort of a night I had had, I told the doctor pretty good, but I had been seeing "devils" while awake.

A morning or two afterwards I had a very pleasant variation of this fantasy. Lying gazing at the walls of the room, I found that the pattern of the wall-paper had vanished, and in its place were exquisite drawings of many favourite subjects of statuary. These remained constant before my vision for an apparently lengthy period, and when the doctor jocularly asked me that day whether I had seen any more devils, I said I had not, but I had seen the walls of the room decorated with such perfect drawings that if I could only imitate them my fortune would be made.

And now I come to one of the most remarkable of these experiences, since it followed on a train of thought and argument to which it was an appropriate conclusion.

For some time before rising and while dressing, I had been engaged in a mental conversation with an ecclesiastic, whom in some way I associated with the Dean of Norwich, although I have never even seen that dignitary of the Church. As in answer to somewhat bitter memories, I was assured by this unknown teacher that the pure love and affections of boyhood and manhood were the links in a living chain by which the angel messengers of the Church were enabled to carry on the work of God, and turn aside evil from the lives of the faithful.

That in this mighty array of spirit messengers all creeds and sects were represented, for it was drawn from all the families of mankind. In especial, through this spiritual channel, there was maintained a union between the Anglican and Roman Churches that, despite all external conflict, was working for the advancement of the race. Loves unconfessed, attachments formed and doomed by the hard realities of existence to live but in the memory only, these, said he, are the links by which the Church Catholic is held together, and the thought and teaching of the ages preserved from corruption and decay, for the Divine message of Love has lived through all times and all races, and is the same to-day as in the beginning, and as it will remain until Love, self-sacrificing but ever triumphant, has conquered lust and cruelty and greed. In this cause all must suffer, for the Church of the Living God values not the love which seeks after selfish

pleasure, and ranks not that true affection which knowingly risks the future welfare of the loved one.

Thus, and in even more authoritative terms, he dealt with the bitter and angry thought by which I had been beset; but I was but half convinced, and almost aloud my rebellious thought replied: "This may be all very satisfactory to you, Sir, but the proof, the proof!" With these words on the tip of my tongue, I turned from the dressing-table, and my glance fell through the old-fashioned window of the room across the yard to where hung, framed in by trees in full foliage, the entrance doors. Everything else around wore its natural appearance, but there, right in the gateway, stood the life-size presentment of a priest in full academic costume, of a good and manly presence. His eyes lit with a smile that dispelled even the thought of fear, he acknowledged my involuntary bend of the head by a courteous raising of his cap, and passed away with a movement so lifelike that only the instant perception that the great doors had not moved convinced me of the non-corporeal nature of the visitant. Now this occurred in broad daylight, about 9 o'clock, on a June morning, yet the effect on the senses was much the same as if the reflection from a powerful lantern had been cast upon the doors as upon a screen.

Of one alone, of many friends in cap and gown, did this mental portrait remind me. He had paused to greet me with such a smile not many weeks before, and as we each turned on our respective ways had passed with such a salutation.

For the next two appearances I have never been able to think of any likely originating cause. Both occurred within a few days of the last-mentioned. The house I was living in was about nine miles east of the neighbouring city, and the window of the bath-room looked to the west. I was washing my hands at the time, and suddenly felt a slight shock, as from a galvanic battery, strike my left side. Looking quickly upwards I saw, apparently suspended over the city, a glittering cross. It was a Latin cross, a yard or more in length, not standing erect, but lying obliquely, with its head to the west, and it scintillated as though formed of magnificent brilliants. The vision soon faded, but not so quickly that my thoughts had not time to reason on the sight. Was it such a vision as this that Constantine beheld, and, if so, why was the cross lying with its arms to the four quarters of the

compass, instead of standing erect? But however that might be, thenceforth I felt convinced that the legend of Constantine was no senseless fable, for there in mid-heaven, in brightest daylight, I had seen the reflected image of a cross flashing with an intense white light.

A similar illusion arresting attention, but with no accompanying train of thought, occurred while I was playing tennis—I think on the following day. Severe and repeated cramping pains in my right arm had compelled me to stop playing, and while I was talking to the friend with me I suddenly started forward on seeing an arc of electric light across the western sky. My friend, who knew the nervous condition in which I was, and alarmed at the fixity of my gaze, hastened to assure me that there was nothing to be seen, to which I responded, “There was, but it has gone now.”

A few days later this same friend and myself were reclining in easy chairs under the shade of the trees. He was reading and I, who had been smoking a cigarette, was in that abstracted state popularly described as “thinking,” though I was really making no effort to pursue any definite line of thought. As we thus sat, I became dreamily conscious of our being concerned in a conversation carried on by invisibles. So far as I could gather, there appeared to be a dispute among the wills of men, who believed that only by an appeal to arms and the supreme arbitrament of life and death could the evils of the world be dealt with. Then I experienced the queer sensation that we were assailed by numberless missiles that fell around us, or sung as they flew past, cutting the leaves from the branches overhead. All that came near us appeared like small flashes of lightning, and powerless to injure us. This fusillade lasted for some time and then ceased, and one party to the preceding argument withdrew, expressing themselves satisfied.

“These men,” said they, “fear not death, and we, who hold it right to slay and be slain at duty’s call in the cause of all we love and cherish, are satisfied.”

And now occurred a curious development. Opposite us, as we sat, was a range of buildings connected with the adjoining farm, presenting on our side a blank surface of stone wall and roof. In the latter appeared the semblance of a dormer window, such as is common in old-fashioned houses, having a lattice opening outwards. This was thrown wide open, and in the aperture a man holding a gun pre-

sented himself. First he hailed us, addressing each by titles, as though challenging the presiding officers of a secret society, and thus conveying to my mind the idea that he represented the secret organisation of such as were prepared to attempt the redress of their grievances by force. Having hailed us, he then covered each in turn with his weapon, while a voice asked, "Have you challenged?" and he replied "Yes."

"What did he answer?"—"Nothing."

"What is he doing?"—"Thinking."

"Then let him think!"

"And the other, what is he doing?"—"Reading."

"Then let him read!"

Then the figure at the window withdrew, and the vision of the window itself vanished, while, apparently from persons in consultation, came the announcement, "We have been on the wrong tack."

The features of the man at the window were well-known to me as those of a retired soldier, who had seen service on the Indian frontier. He was a seven-years' man, and though proud of his service under the colours, he and the bulk of his comrades had been too dissatisfied with the regimental control to enlist for a further period. He had resumed the calling he had followed as a boy, and having occasion for his services he had been for some time in my employ, but I cannot recall having ever seen him at an open window handling a gun.

In this case, therefore, there were two distinct scenes coming and going, and for a time superposed, in the electric lanterns of the eye. First, the picture of the dormer window with the opening casement, and then the appearance of the man and his moving away from the window before the likeness of it faded from the roof of the building, of which, while it lasted, it was apparently a structural part.

For the associated dialogue I could think of no likely originating cause. In a vague way it had at the time impressed me with the idea that it had relation to the Irish Secret Societies; but there was no direct allusion, and the titles used afforded no clue.

In the instance I am now about to relate there was no accompanying speech, but the import of it appeared at the time to be an assault upon a cardinal doctrine of our Faith. During the afternoon I had visited an old lady,

whom I found sitting up in bed reading. Afterwards I took a walk through the neighbouring fields and lanes, and on nearing her house on my return I glanced up at the window of her room. Again a mental vision was incorporated with the actual scene. As from the window I saw the picture of the old lady, seated as I had last seen her, slowly ascend until lost in the azure of the sky. Just for an instant, the thought occurred to me that she might have died since I saw her, but the suggestion was at once repelled by my reasoning faculty, the thought being instantly answered by the mental comment—"No, it is not in such fashion that the spirit of life is called home to its eternal source." But I am free to admit that it was with a sense of relief that I found, some few hours afterwards, that the dear old lady was in her usual health, and, needless to say, I did not speak of the queer trick my eyes had played me, for I did not think her life would be made any the happier, or her hopes of heaven any the surer by recounting my experience.

Most people, at some time or other, I suppose, have caught themselves in the fancy that some person approaching them in the passing crowd is an acquaintance, and perhaps only discovered their mistake when at close quarters, just in time to save themselves the annoyance of greeting a stranger. The reason of this I take to be that some fancied resemblance is suggested to the "identification department" in the visual faculty, and the thoughts being preoccupied, or the brain tired, the energy required to establish or refute the suggestion is not put forth until much later than would be the case if one was thoroughly "wide awake" at such a time. I pass over, therefore, mere momentary confusion of sight easily traceable to such causes, and will conclude with recording two or three visions which presented themselves some two months later.

Of these, one would be uninteresting save for the fact that it seemed a suggested picture, though how or why the memory was recalled I am unable to say. With the friend previously alluded to, I had been strolling along the banks of a small trout stream, watching the fish in the pools, and towards the end of our walk my friend, himself an ardent fisherman, stopped to discuss, with a fresh arrival in the village, the prospects of sport. While talking, the stranger suddenly bent forward to pick something from the turf, holding his rod erect with one hand and reaching far out

with the other, while to preserve his balance he extended one leg high in the air. At the time his attitude suggested to my mind an amusing resemblance to the three-legged bearings of the Isle of Man, but I thought no more of the incident as just then their conversation ceased and my friend turned to rejoin me. A few days after, this same friend was idling away the time by searching the surrounding hills with a fairly good telescope. Suddenly he passed me the glass, saying, "Look! There is a man up at the signalling flagstaff." Sure enough, I saw a man in that glass, but scarcely the one he expected, I think, for what I saw was the mental photograph of the fisherman in the attitude I have already described. I was tired, the incident seemed trivial and uninteresting, and being in no mood to discuss it, I returned the glass in silence.

On another occasion, accompanied by a mutual friend, we had been down to the old harbour of the adjoining town, where once a considerable local trade had been done, although the shipping is now confined to a few fishing boats, an occasional yacht, or a small collier. It was about mid-tide, and as we came round the head of the harbour we stood for a few minutes looking down from the parapet of the roadway at the water below.

Then from out the waves I saw advancing the figure of a man grasping a staff, each hand towards one of the ends, and carrying it horizontally. Only his head and shoulders were visible when I first became conscious of the sight, and I was on the point of calling attention to his dangerous position when I received a mental warning to give no sign of surprise, nor in any way try to call the attention of my comrades to what I was witnessing. Meanwhile the apparition—for such I had by this realised it to be—slowly advanced into shallower waters, and when clear from about the knees upward faded into nothingness. At the same time it seemed as though a voice whispered, "Behold! the sign of the man rising from the waters, holding the staff of the two Houses." In this case I had the curious impression that one or both of my friends were also witnesses of this illusion; but, however this might have been, the sum total of our knowledge would not have been enhanced by discussion. Mentally, I concluded that the original of this visual photograph was a friend of ours whose passion for the piscatorial art led him to spend hours in wading the larger trout streams of the country.

The next and last of these experiences affected my nerves more strongly than any of the preceding—not so much at the

time as for some days afterwards, during which it formed the basis of strange dreams and fancies. I cannot altogether place it in the same category as the foregoing, and if I had then heard of Captain Rowland Scott's invention for cloud signalling and sky advertising I should have felt sure I was witnessing an experiment of that nature. It was about 10 p.m., and I was on my way to the rooms where we were staying, when suddenly I saw a great circle of light travelling across the sky and finally alighting on and encircling the full moon. What strange phenomenon was this? Was it the ring of Saturn slipped from its allegiance and come to adorn our attendant satellite? And what was this black monster, whose dragon-like head and coils stretched across the heavens and seemed to threaten to engulf the newly-ringed Goddess of the Night? Bah! At once my reason recovered its balance. That, at all events, was but a shadowy reflection, whatever the explanation of the other striking sight, for that also had by this vanished. Some month or so afterwards I saw in the possession of an astronomical enthusiast, living not many miles away, a walking-stick cut from a gnarled and twisted root, the very *fac-simile* in shape of the shadow whose horrible form had seemed to darken the whole western sky.

Having told my tale, I will leave it to convey its own lessons according to the understanding of its readers, save only that it be not perverted to serve selfish ends or forge anew the fetters of superstition. Let language be used to instruct and not to mystify the ignorant, and then, maybe, press, platform, and pulpit will resound with less discordant cries than now make confusion the worse confounded. "Supernatural," rightly interpreted, means that which is *above* our comprehension of natural law, and since our comprehension of natural law cannot possibly set a limit to its operations, it is both misleading and absurd so to use the word as to imply that which is contrary to Nature. In fact, I am by no means satisfied that our "physical" doctors are not greater offenders against Nature than the "spiritual" pastors of the Church; and the tyranny of their mysteries is not more to be desired than the older priestcraft; but to either the one or the other I would more readily commit the guidance and rule of the people than to the new profession of women-inspired prophets, who would inaugurate a millenium for sensation mongers and idle sentimentalists, while leaving untouched the burdens and sorrows of the children of Nature.

Insanity in English Local Prisons, 1894-95. By JOHN BAKER, M.B., C.M., H.M. Prison, Pentonville.

From time to time it is confidently asserted in the public Press that not only is insanity rapidly on the increase in English prisons, but that the present system of administration is largely responsible for this state of affairs. Such statements appear to be circulated without a real knowledge of the facts, and they tend to unsettle and mislead the public mind. With the object of showing that imprisonment, as at present conducted, has not the deteriorating effect on the nervous system that it is alleged to have, the following tables, founded on an examination of Table E, Commissioners of Local Prisons, Report, England, 1895, have been prepared. Before entering into statistical details it may not be out of place to state that increased interest has recently been displayed in things pertaining to criminality and to the physical, moral, and intellectual characteristics of the criminal. There can be no doubt that the somewhat extravagant views held by a section of continental criminologists have met with a ready acceptance in certain quarters in this country. Attempts have been made to prove that the stigmata, physical and psychical, said to have been observed amongst Italian criminals, are also present in English felons. These stigmata are to be found in varying and uncertain proportion amongst a part of the population of our prisons, but not, in my opinion, to such an extent as to warrant the assumption that there exists a special criminal type or a distinct criminal neurosis. Receding foreheads, square chins, large ears, and tattoo marks are but poor data on which to base a pathological criminology, but safer ground is reached in the presence of contorted and narrow palates, of heart disease, and tubercular affections, of the after-effects of syphilis and intemperance, all of which are to be frequently met with amongst criminals.

When an attempt is made to draw an analogy between the Italian criminal and his English prototype, certain facts ought to be borne in mind, viz., that no institution similar to Broadmoor Asylum exists in Italy, that a Committee which reported on the provisions to be made for the criminal insane in that country, a number of years ago, arrived at the conclusion that the number of lunatics confined in Italian prisons was very large; further that the populace

regard capital punishment with intense hatred, and in consequence numerous criminals with life sentences, many of them probably insane, are associated with other convicts. It does not therefore follow, apart from differences, racial and otherwise, that the observations of distinguished foreign alienists will receive confirmatory evidence when English criminals are in review. Various reasons can be adduced to show that comparatively little value attaches to the recent criticisms on the alleged increase of lunacy in English prisons. The method of basing the ratio of insanity on the daily average number resident is improper and fallacious. The proportion of recoveries amongst the registered insane is calculated not on the daily average number resident, but on the total admissions, and it is only reasonable that the ratio of certifiable insanity in prisons should be reckoned on the same basis.

The daily average resident population of the English local prisons for the year ending 31st March, 1895, was 14,229. The number of prisoners certified insane was 389. By this method of calculation the proportion of insane criminals reaches the enormous total of 273 per 10,000. Large numbers such as 10,000 (this is the number usually employed), convey but a loose and inadequate perception to the mind, but when examined more closely, the unpleasant fact is revealed that one prisoner in thirty-seven in our English prisons is apparently the subject of mental disease. Even to those who have no conception of prison life, this ratio must appear absurd, and it is scarcely credible that such a method of calculation should have been seriously adopted. It is opposed to all the facts of true psychology and, it may be added, of true statistics. How unreal this proportion is will be more readily understood when we know that the daily average number resident, viz., 14,229, represents no fewer than 159,870 receptions, the majority of whom are distinct individuals.

The term majority is used advisedly, because reasonable objection may be taken to founding the ratio of insanity on the number of prisoners received. They include reconvictions, *i.e.*, persons who have been in prison more than once during the year. No statistics are available for clearly estimating the number of persons received, as opposed to cases, but an approximation affording a fair basis for calculating the rate of insanity may be arrived at. In Appendix No. 9 of the same Blue Book the number of reconvictions is

given as 85,204. Deducting this number, 85,204, from the total number received, viz., 159,870, it is evident that 74,666 persons were committed to prison for the first time. It is difficult, with any approach to accuracy, to estimate the number of persons represented by the 85,204 reconvictions, but even assuming that all their previous convictions took place within the year in question, which is taking the least favourable view for our contention, they represent some 25,000 individuals. Actually they represent a larger number. Taking them in conjunction with the 74,666 first commitments, it will be seen that, roughly speaking, some 100,000 separate and distinct individuals, in all of whom there was the possibility of insanity occurring, passed the prison portals as criminals, during the year ending 31st March, 1895.

The true ratio of insanity therefore appears to be 38·9 per 10,000, a proportion almost identical to that of the registered insane in Ireland, and somewhat in excess of that of England. If the proportion be calculated on those entering prison for the first time, the ratio only amounts to 52 per 10,000, *i.e.*, without reckoning any reconvicted prisoners. There is a very appreciable difference between these figures and 273 per 10,000, and shows the utter fallacy of any method of calculation based on the average daily number resident of a population which is constantly changing.

Having considered the general argument, it now remains to discuss, in their various bearings, the points connected with the 389 cases certified as insane.

The table on next page shows that not only are the great majority of the cases mentally unsound on reception, many of them being remanded from the courts for observation, but that a considerable number are ascertained to have had previous attacks of insanity.

It daily occurs in the larger prisons that real or suspected cases of insanity are placed under observation on reception. With regard to the latter, some time must naturally elapse before a correct diagnosis can justifiably be made. Amongst other considerations, the element of possible malingering has to be eliminated. No matter how short the time may be, the mere fact of the insanity, if proved, having occurred in prison is adversely commented upon. One of the difficulties which prison medical officers have to contend with is the frequent absence of any trustworthy information bearing upon the antecedents and family histories of prisoners. In spite of this and other obstacles, only 53 of

TABLE I.—Showing (a) the form of insanity in the 389 cases certified insane in the English Local Prisons during the year ending 31st March, 1895. (b.) The numbers respectively (1) of those in whom symptoms of insanity were found on reception; (2) and of those in whom the symptoms appeared subsequently. (c.) The numbers remanded from the Courts for mental observation. (d.) The number in whom a previous history of insanity was ascertained.

	a.			b (1).			b (2).			c.			d.		
	Form of Insanity.			Mentally unsound on reception.			Mental Symptoms appeared subsequent to reception.			Remanded for observation.			Previously insane (ascertained).		
	M.	F.	Tot.	M.	F.	Tot.	M.	F.	Tot.	M.	F.	Tot.	M.	F.	Tot.
Congenital Imbecility—															
Without epilepsy	17	4	21	16	4	20	1	—	1	6	2	8	4	1	5
With epilepsy	5	—	5	4	—	4	1	—	1	2	—	2	2	—	2
Epileptic Insanity	14	2	16	10	2	12	4	—	4	6	—	6	4	—	4
General Paralysis	31	1	32	27	1	28	4	—	4	10	—	10	5	—	5
Mania, Acute	29	17	46	21	17	38	8	—	8	7	14	21	—	—	—
à Potu...	5	2	7	4	2	6	1	—	1	—	—	—	—	—	—
Chronic	8	5	13	7	5	12	1	—	1	4	4	8	—	—	—
Recurrent	30	15	45	28	13	41	2	2	4	21	7	28	30	15	45
Melancholia	51	33	84	43	33	76	8	—	8	28	22	50	13	10	23
Monomania of suspicion and persecution	18	3	21	18	3	21	—	—	—	13	—	13	3	—	3
Delusional Insanity	31	10	41	25	8	33	6	2	8	9	4	13	9	2	11
Dementia	35	12	47	28	7	35	7	5	12	10	4	14	18	4	22
Senile Dementia	7	4	11	6	4	10	1	—	1	—	4	4	—	—	—
	231	108	339	237	99	336	44	9	53	116	61	177	58	32	90

TABLE II.—Showing the relation of the various forms of insanity with different phases of crime in the 389 cases certified insane in the English Local Prisons during the year ending March 31st, 1895.

Form of Insanity.	NATURE OF CRIME.															Totals.		
	Murder.	Attempted Murder.	Manslaughter.	Assault and Wounding.	Attempted Suicide.	Sexual Offences.	Larceny.	Burglary and found on Enclosed Premises.	Arson.	Damage, Wilful.	Vagrancy and Wandering.	Fraud and False Pretences.	Drunk and Disorderly.	Other Minor Offences.	M.	F.	Total.	
Congenital Imbecility—																		
Without Epilepsy ...	0 0	0 0	1 1	—	1	3	5	1	—	1	3	1	—	1	17	4	21	
With Epilepsy ...	0 0	0 0	—	3	—	1	—	1	—	—	—	—	—	—	5	—	5	
Epileptic Insanity ...	1 1	1 0	—	3	1	1	3	1	0	—	1	1	1	1	14	2	16	
General Paralysis ...	0 0	0 0	—	—	—	2	18	3	1	1	2	1	2	1	31	1	33	
Mania, Acute ...	1 3	1 0	—	4	1	1	8	1	1	4	1	0	1	5	29	17	46	
à Potu ...	0 0	0 0	—	—	—	—	1	1	—	—	—	—	1	2	5	2	7	
Chronic ...	0 0	1 0	—	3	2	—	2	—	—	1	0	1	1	0	8	5	13	
Recurrent ...	3 1	1 0	2	6	2	2	3	—	—	1	1	2	4	5	30	15	45	
Melancholia ...	1 5	0 3	1	6	2	4	3	1	—	1	1	2	1	2	51	33	84	
Monomania of Suspicion and Persecution ...	0 0	1 0	—	1	3	—	1	—	1	6	2	—	2	—	18	3	21	
Delusional Insanity ...	1 1	1 1	—	7	2	1	8	2	—	1	1	—	2	8	31	10	41	
Dementia ...	0 0	0 0	—	3	3	5	5	1	—	2	5	2	3	4	35	12	47	
Senile Dementia...	0 0	0 0	—	1	—	—	2	—	—	—	3	—	1	—	7	4	11	
	7 11	6 4	4 1	37 11	40 22	20 0	53 7	11 —	5 —	18 4	20 12	8 4	16 17	31 15	281	108	389	
	18	10	5	48	62	20	65	11	5	22	32	12	33	46			389	

TABLE III.—The factors of the insanities, so far as ascertained, in the 389 cases certified insane in the English Local Prisons for the year ending March 31st, 1895.

	M.	F.	Total.
MORAL.			
Domestic trouble, including loss of relatives, friends, etc. ...	7	6	13
Adverse circumstances (loss of work, business worries, etc.)	13	2	15
Mental anxiety (overwork, etc.)	3	1	4
Religious excitement	4	2	6
Love affairs	—	2	2
Sensational literature... ..	1	—	1
PHYSICAL.			
Drink	34	15	49
Sexual intemperance	—	1	1
Self abuse	8	0	8
Syphilis	3	3	6
Sunstroke	4	—	4
Parturition	—	1	1
Lactation	—	3	3
Menopause	—	5	5
Menstrual	—	1	1
Adolescence	1	—	1
Old age		4	11
Privation	3	2	5
Bad health	1	1	2
Strumous	2	1	3
Head injury	3	0	3
Epilepsy	13	2	5
Congenital	22	4	26
Hereditry	7	5	12
Previous attack	51	19	70
Unknown	94	28	122
	281	108	389

the 389 cases are described in Table E (Blue Book) as mentally sound on reception. They will be dealt with later. Nearly one-half (177) were remanded from the courts for mental observation, and in 90 cases a previous history of insanity was ascertained. These no doubt form part of the mass of unregistered lunatics wandering at large about the country. Their mental condition is either undetected or ignored until they are committed to prison for some offence against the law. A consideration of Table II. will indicate that a number of dangerous and insane criminals are being annually eliminated from the ranks of the community, and it further goes to prove the correctness of some well-established facts, viz., the violence of epileptic insanity, the proneness of general paralytics to acts of petty larceny, the dangerous nature of delusional insanity, and the aimless crimes of demented.

The form of insanity in many of the cases is conclusive evidence that mental defect existed before reception into prison, *e.g.*, congenital imbecility, congenital epilepsy, general paralysis, mania à potu, and recurrent mania. The same may be said of many of the crimes. There were eighteen insane murderers, ten attempts at murder, and five cases of manslaughter by people mentally afflicted, and no fewer than sixty-two cases of attempted suicide. What possible connection can be traced between the alleged adverse influence of prison discipline and treatment and the production of the insanity in those cases? Yet they are all reckoned in the general average. The prison system is by no means perfect, but it is free from responsibility for many of the evil effects incorporated in the charges levelled against it. Progress is the order of the day, and many improvements are gradually being introduced, not only to alleviate the physical condition of the criminal, but to elevate his moral and mental well-being.

Table III. serves the purpose of proving that external causes were at work in the causation of mental disease in a large number of instances.

In 68 per cent. the exciting cause of the insanity was ascertained and recorded; in the remaining no history was obtainable.

Table IV. deals with those cases in which the insanity was discovered subsequent to reception.

In reviewing these 53 cases it will be noted that seven became insane within one week, and six more within two

weeks after reception. They include one case of congenital epilepsy, four of epileptic insanity, four of general paralysis, one of alcoholic mania, and four of recurrent mania. The seeds of disease undoubtedly existed in those cases at the time of reception. With regard to the remaining 39 cases, the effect of imprisonment may have been a determining factor in the production of the insanity. Admitting this as a feasible explanation, if the ratio be calculated on the total number of persons received, the proportion of insanity which could be ascribed to prison discipline and treatment amounts to 1 per 2,500. To those conversant with criminals, this is more in consonance with actual facts than the extraordinary proportion of 1 in 37. No doubt in some instances imprisonment does disturb the equilibrium of the nervous system, more especially in those of weak and unstable organism; in connection with this the severe mental strain involved in awaiting trial, the excitement of the legal proceedings, and the subsequent reaction, have to be taken into account. On the other hand we have met with isolated cases in which there was reason to believe that the prisoners' environment had adversely affected them. They embrace instances of melancholia induced by brooding over the barren vista of years to be spent in a long term of penal servitude, and of delusional insanity, probably due to the prolonged process of introspection, almost inseparable from cellular confinement. These cases, however, are few and far between, and extend over the range of a number of years.

The foregoing remarks are exclusively related to cases of insanity, and do not include those persons who are weak-minded, but not actually or legally insane. The recent criticisms were no doubt developed with the best of motives, but the nature of the insanities, the character of the crimes, the possible influence of external causes, and, above all, the numbers of the prison population, appear to have been overlooked in endeavouring to arrive at a conclusion regarding the apparent high rate of lunacy in the English local prisons.

*Pseudo-General Paralysis.** By THEO. B. HYSLOP, M.D.,
Assistant Physician, Bethlem Royal Hospital.

By using the expression pseudo-general paralysis I am quite aware that I lay myself open to criticism. It may be said that the term is not only useless, but even misleading. Some will say the diseases under question are either instances of general paralysis, or, if not of general paralysis, they are other forms of disease and ought to be named accordingly. In anticipation of such an objection I venture to remark that the term general paralysis, as at present used, tends to cover many cases which are not truly *general* paralyzes, but rather cases of insanity associated with a form of paralysis which strictly speaking is only partial. Or, to put the matter conversely, are we not too apt to include under the term general paralysis cases which are really cases of special paralyzes associated with insanity?

Perhaps it might be well to look for a moment at the twofold meaning, in extension and intention, of the term general paralysis. By extension we of course refer to the objects to which the term may be applied, and by intention we mean the qualities which are necessarily possessed by the objects included under the term. For example, just as the term metal denotes gold, silver, etc., so the term paralysis denotes tabes, hemiplegia, etc. Further, just as the word malleable qualifying metal narrows the denotation of the term metal, so general applied to paralysis narrows the denotation of paralysis. In the present instance the addition of "of the insane" renders the denotation of the expression still more limited. In fact the limitations involved are so great that there is a distinct tendency to be illogical in including under the term, as we know it, either paralyzes occurring in the not-insane, or paralyzes which, more correctly speaking, are partial (although progressive) occurring in association with insanity.

This limitation imposed upon us naturally makes us look for a disease which we can regard as truly general in contradistinction to partial. The only exemplification is in the stage immediately preceding dissolution, and this I take to be the explanation of the wonderful truism that true general paralysis is invariably fatal. I do not wish, how-

* Read at the Cambridge Meeting of the Medico-Psychological Association 20th February, 1896.

ever, to quarrel with the nomenclature. The term general paralysis may be advisedly descriptive of a certain affection which is progressive and which terminates fatally. At the same time it appears to me that we who have the opportunities of observation should, instead of countenancing possible misconceptions by the use of an ill-defined term, seek rather a more complete differentiation of the factors of this chaotic disease and surrender the term "general" to what we really regard as special though progressive. For my part I have always failed to appreciate the entity theory of general paralysis. As it at present stands, general paralysis would appear to be best defined as a progressive disease which begins anyhow but ends somehow.

We are all conversant with the classical descriptions of general paralysis, and occasionally we see cases which fall under the recognised types. But the inclusion of the exceptions, which appear to be more numerous than the confirmatory cases, has always appeared to me to be merely a matter of convenience and in reality only a cloak for our ignorance of the special nature of the paralyses.

One of the greatest authorities of the day upon general paralysis defines it as "a disease of the nervous system, especially of the brain, marked clinically by some general affections of motility, viz., ataxy, and finally paresis, usually following a definite order and course of development, and especially obvious in the apparatus of speech and of locomotion; also, but in a less degree, by sensory disorder or defect; and marked also by mental symptoms, which constitute, or invariably tend to, dementia, but often consist in part of exaltation of feeling, or even expansive delirium. Finally, it is evidenced by certain organic changes in the encephalon and its tunics, often in the spinal cord and membranes also, and sometimes in some sympathetic ganglia as well."

Another eminent authority says, "general paralysis is not only a variety of insanity but a true cerebral disease, as distinct from any other disease as small-pox is from scarlatina. Being a distinct disease, it can be defined or described definitely." It is therefore defined as "a disease of the cortical part of the brain, characterised by progression, by the combined presence of mental and motor symptoms, the former always including mental enfeeblement and mental facility, and often delusions of grandeur,

and ideas of morbid expansion or self-satisfaction; the motor deficiencies always including a peculiar defective articulation of words, and always passing through the stages of fibrillar convulsion, inco-ordination, paresis and paralysis; the diseased process spreading to the whole of the nervous tissues in the body; being as yet incurable, and fatal in a few years." The same author next proceeds to the description of its variations, the most marked varieties being the peripheral form, where the pathological process does not begin in the brain cortex but in the cord, or in the neurine portions of the organs of special sense, or in the peripheral nerves. Both these descriptions are by advocates of the entity theory, and this much I am prepared to admit. The wide-reaching inclusion of factors in the olla podrida of general paralysis is unequalled in any other disease, and in that sense it can claim, as I think, to be distinct from any other disease.

Now before we can decide the question of the existence of truly *general* paralysis, we have to ask the question, what are its symptoms, and how are we to distinguish them from those of progressive partial paralyses?

From the physical point of view there are innumerable forms of paralysis which are "evilenced by certain organic changes in the encephalon and its tunics, often in the spinal cord and membranes also, and sometimes in some sympathetic ganglia as well." From a pathological standpoint, therefore, general paralysis, as we at present know it, seems to include every known cerebral degeneration as possible adjuncts of its pathology, *i.e.*, it includes many affections which often, occurring independently, are in reality special paralyses. From the physical side I consider that we have two broad types of disorder with which to deal, namely: paralyses which tend to progress and become more or less general, and paralyses which tend to progress, but which nevertheless remain, broadly speaking, only partial. Provisionally, therefore, I accept this as my text.

From the mental side we have nearly every possible abnormal mental manifestation included under general paralysis. The symptoms are said "invariably to tend to dementia, but often consist in part of exaltation of feeling, or even expansive delirium." The usual halo around the idea of expansive delirium seems to be quite sufficient for the diagnostic purposes of some observers; but how often do we really meet with it in the cases we are in the habit of

calling cases of general paralysis? And how often do we meet with it in cases which we know are not cases of general paralysis? At once the obvious reply is "certainly we do not diagnose general paralysis from the psychical side alone; in fact, we grant that there are no symptoms which invariably indicate the existence of a disease which is an entity, but the existence of a certain well-defined group of psychical symptoms associated with another well-defined group of physical symptoms would appear to warrant the conclusion that their co-existence is indicative of a disease which we may fitly describe as general paralysis."

General paralysis, as I understand it, is a disease in which there is progressive paralysis of all mental and physical functions, terminating respectively in complete dementia and complete paralysis. Strictly speaking, the only condition which fulfils all those expectations is, as I indicated before, death; and my belief is, that so-called general paralysis is merely a term used to signify the existence of widely varied partial paralyses (spinal, bulbar, and cerebral), associated with pathological affections of the organic substratum of mind, and therefore of the individual. The title of my paper, however, is *Pseudo-General Paralysis of the Insane*, and I will at once explain that by pseudo-general paralysis I mean to imply the existence of certain forms of paralysis which are like general paralysis, and which have been mistaken for it, but which in reality are, truly speaking, partial paralysis (mainly cerebral), with associated mental degenerations. Far be it from me to suggest the existence of a disease which might bear the name of pseudo-general paralysis. I have no such intention. I merely suggest that some cases so called are not general paralysis, and that under the general term there is a possibility of misconception.

The discovery of general paralysis was said by Baillarger to have been the most prominent advance recorded in the history of mental disease. As a matter of fact the discovery consisted in the recognition that dementia associated with paralysis and bulbar symptoms formed in some instances an incurable affection. Georget, Delaye, and Calmeil regarded the malady as a special form of paralysis superimposed upon the insanity. Bayle and Parchappe, on the other hand, regarded general paralysis as a special form of insanity characterised by certain anatomico-pathological characters and designated paralytic insanity. Subsequently Requin, Sandras, Lunier, and Baillarger somewhat

modified their views and recognised that general paralysis may exist with or without mental symptoms. Baillarger further claimed that, from a psychical point of view, the dementia and not the delusions constituted the essential symptom of the disease. Since that period the numerous anatomico-pathological lesions found post-mortem have led to the belief that this so-called entity is a chronic meningitis or meningo-encephalitis, a sclerosis of the connective tissue of the brain, a degenerative lesion of the great sympathetic, a myelitis, a diffuse, chronic, interstitial, meningo-myelo-encephalitis, and, lastly, an affection beginning in the brain cortex, or in the cord, or in the neurine portions of the organs of special sense, or in the peripheral nerves. Régis states, and I believe truthfully, that new clinical facts, such as the remissions, latent general paralysis, general paralysis of the double form, and in particular syphilitic saturnine and alcoholic pseudo-general paralysis, have gradually overthrown the entity theory which fails to explain them. General paralysis, as we know it, is a paralytic dementia essentially made up of a dementia and a progressive paralysis; and using the term general paralysis as thus understood, I now proceed to mention some of the more common of what have been called pseudo-forms, *i.e.*, those forms which simulate progressive paralysis, with or without dementia, but with no fulfilment of the rôle.

Examples of Pseudo-Form.

Epilepsy may lead to complete fatuity, or definite paralysis, or definite paralysis may result from local lesions in the brain structures. Some cases resemble general paralysis in their main symptoms, inasmuch as there is progressive mental degeneration associated with the steady development of a paralysis which tends to become general, and is attended with emaciation.

Alcoholism.—The late Professor Ball, Lacaille, Rousset, and many others have admitted the existence of, and described *alcoholic* pseudo-general paralysis. From the symptomatic point of view the similarity is well-nigh complete, but these pseudo-forms differ in that they are essentially curable, or at least susceptible of amelioration under appropriate treatment. They begin either with epileptiform or even apoplectiform attacks, or the pseudo-paralysis immediately follows a subacute attack of alcoholism. The symptoms almost at once attain their greatest severity. Inequality of

the pupils is almost invariably present, and, according to Régis, "the pupils are invariably very paretic, and in some cases absolutely immobile, especially the one that is most dilated. Besides this the pupillary aperture is very often misshapen, oval, notched on its borders; the coloration of the pupil loses its sparkle and transparency; it is usually dull and cloudy; and, lastly, the visual acuteness is ordinarily diminished—these last peculiarities being exceptional in general paralysis." The mental state is not one of progressive enfeeblement, but rather of confusion and stupidity. These bodily and mental symptoms gradually disappear, the inequality of the pupils being the most fixed and durable of the symptoms. The speech affections, on the other hand, tend to improve early. Such attacks may be repeated time after time. Professors Ball and Régis have reported a case in which alcoholic pseudo-general paralysis was recovered from 16 times in 13 years. Ultimately, however, such patients become alcoholic demented.

Saturnine.—Poisoning by lead gives rise to the form of insanity known as Saturnine. Several investigators have described a form of disorder closely resembling general paralysis to which they have given the name of saturnine pseudo-general paralysis. For an account of this affection I am again indebted to Régis. He says: "Like alcoholic pseudo-paresis, the saturnine pseudo-general paralysis most generally develops in the course, or rather as the result, of a subacute attack of saturnine insanity. Contrary to what occurs in true general paralysis, its beginning is abrupt, it breaks out noisily and reaches its apogee at once. As soon as the hallucinatory and delirious symptoms that constitute the lead intoxication have passed off, the pseudo-general paralysis appears, not with the mild symptoms of the period of invasion, but with the gravest characters of the full-fledged disorder. In most cases the patients are plunged from the beginning into the most profound cachectic marasmus. They are untidy, paralysed, demented, incapable of making a movement or uttering a syllable, and seem to be on the point of succumbing. At the same time they present the usual symptoms of lead intoxication, such as the blue line on the gums, clayey complexion, cephalalgia, dizziness, cramps, various neuralgias, partial anæsthesias or hyperæsthesias, paralysis, epileptic or eclamptic disorders, etc." "The symptoms common to true general paralysis and saturnine pseudo-general paralysis, present in the latter

some special shades of difference. Thus the pupillary inequality is often lacking, the tremor, while more intermittent, is also more marked and spasmodic, and the embarrassment of speech is occasionally so marked at the beginning that the voice is unintelligible. The patients, as we have seen, are often untidy and completely paralysed on their first admission to the asylum. Mentally, besides the delirious and hallucinatory manifestations, which speedily disappear, they show a type of depression very different from that of general paralysis. While, in ordinary paretics, the mental enfeeblement, at first slight, follows a progressive course and finally terminates in complete dementia, in the case of saturnine pseudo-general paralytics, this enfeeblement which appears at once in its greatest intensity, is much more apparent than real."

There are many other facts which are essential to the determining of a complete differential diagnosis. It is especially as regards its course and prognosis, however, that saturnine pseudo-paralysis is distinct from true progressive general paralysis. The affection is an essentially curable one, and, like alcoholic pseudo-paralysis, it has a decided tendency to recur under the influence of the same causes.

Fevers.—Febrile affections are not uncommonly complicated with or followed by mental disturbances. Typhoid, typhus, small-pox, scarlatina, cholera, diphtheria, influenza, and malaria may be followed by physical symptoms which, when associated with insanity, closely simulate progressive paralytic dementia. The general constitutional disturbances and degeneration of the tissues of the cerebro-spinal system which occur in pellagra also sometimes simulate general paralysis. After *typhoid* there may be affections of speech or ataxy of movement. As mentioned by Mickle, the speech is sometimes slow, and exhibits a characteristic drawl; the syllables are articulated in a monotonous tone, and with a nasal twang. The affections of the motor system may further be evidenced by muscular weakness, with or without tremors or tremblings of the lips, facial muscles, or even limbs. Westphal has described a peculiar trembling of the head when unsupported in a case in which there were no lip tremors, and in which sensation was unaffected. The pathology of this condition is little known. In chronic cases terminated by death in asylums, anæmia of the brain, or atrophy of the cortical substance, opacity of the pia mater, and excess of the subarachnoid fluid have been found. These

cases do not run the usual course of general paralysis, but tend to become chronic in the form of partial dementia, dementia, or of paralysis associated with delusions, and termed by some authors pseudo-general paralysis. Many other febrile conditions are followed by various paralyses and insanity. It would involve too much time, however, to enter upon the consideration of these affections. General paralysis is said to follow typhus, cholera, typhoid, dysentery, diphtheria, pneumonia, articular rheumatism, erysipelas, etc. I believe, however, that these affections are followed much more commonly by localised or even diffused paralyses which simulate general paralysis in many respects, but differ from it in that the course of the disease is widely divergent and the pathology consequently at variance.

Malaria.—The pseudo-general paralytic type of insanity following malaria has been repeatedly observed. It sometimes presents most of the features of general paralysis, with mental and physical symptoms, which, although difficult to distinguish from those of general paralysis, are, nevertheless, somewhat different in their course and duration. Mentally, there is frequently weak-mindedness or slight exaltation, with or without marked delusions. In one case admitted to Bethlem there was partial dementia with confusion, and in another, confusion and hallucinations of hearing. The physical symptoms were those of nervous debility with tremors, alteration of the reflexes, and even definite symptoms of a cord lesion. Although the pathology of such cases is as yet indefinite, there is sufficient evidence to warrant the conclusion that the affection is probably due to micro-organisms or to the existence of pigmentary deposits. From the clinical standpoint the diagnosis is often a matter of extreme difficulty. The periodic or intermittent nature of the mental troubles may suggest a malarial origin. The diagnosis would appear to rest between malarial pseudo-general paralysis, insanity with paralysis, and progressive paralytic dementia or general paralysis. Mental disorders occurring during an attack of malaria are generally transitory and curable unless the malaria be of undue severity, when there is apt to be permanent instability or chronic insanity. The prognosis in the pseudo-general paralytic forms is, in my experience, more unfavourable than in the other varieties of pseudo-general paralysis. They seldom terminate like general paralysis, but go on for years, and die of some complication, or succumb to the advance of a special degenera-

tive lesion. Sometimes when alcohol has formed an additional factor of causation the case may do well. When syphilis forms a complication recovery is rare. In one case formerly in Bethlem, with a history of malaria and syphilis, there was partial dementia with hallucinations of hearing and lateral sclerosis of the cord. The mental symptoms on the one hand were of an intermittent type, and did not advance in severity, whilst, on the other hand, the lesion in the cord progressed unfavourably until death ensued.

Syphilis.—The relationship of syphilis and insanity is a subject fraught with much difficulty, and hitherto it has provided much matter for contention. The literature of the subject is so extensive, and the conclusions of various observers so contradictory, that I may well be excused from propounding any definite statements with regard to it. It is difficult to prove that syphilis is the actual and immediate cause of insanity. The most one can say is that the syphilitic virus does induce pathological changes in the vascular and connective tissues of the cerebro-spinal system, and these changes act mechanically by pressure or otherwise, and so modify the nutrition of the nervous structures as to impair their functions.

It is impossible to define the organic types from the clinical symptoms alone, for any one symptom may be simulated by many other factors, a syphilitic tumour may be simulated by an abscess, hydatid cyst, or glioma; or the hemiplegia due to thrombosis of an atheromatous cerebral artery may not differ from thrombosis due to syphilitic arteritis. We can, in some cases, only rely upon the history of syphilis with its succession of symptoms. By some authors syphilis of the nervous system is said not to exist. They maintain that it does not attack the nervous substance, but that it affects the neuroglia, fibrous tissue, blood-vessels, lymphatics, membranes, or horny coverings, involving the nerve tissue only secondarily by pressure, and so causing irritation, inflammation, etc., or by starvation from deficient blood supply so causing degeneration and atrophy.

There is a group of symptoms which has been repeatedly described, and which possibly may be due to inherited syphilis. These symptoms occur in children, and sometimes present a remarkable resemblance to those of early general paralysis. The salient features of some of them are slow but steady development of paralysis with great emaciation. I have seen several cases of this type, and I am unable

to say upon what grounds they are sometimes regarded as cases of general paralysis. In adults the syphilitic process may attack the cerebral vessels and cause thrombosis, with subsequent atrophy, or the gummatous material may affect the surface of the convolutions or the internal tracts. Possibly the same occurs in children who are congenitally affected by syphilitic disease.

Syphilitic disease may manifest itself in lesions of the bones of the cranium, the membranes, blood-vessels, brain substance, cerebral nerves, or of the organs of special sense. The skull bones may be absorbed owing to gummatous infiltrations, or small areas of caries with exfoliation may occur. The dura mater and the pia arachnoid may be thickened and affected by various inflammatory deposits, or there may be gummata. The middle and inner coats of the arteries may show the characteristic endarteritis. Inflammatory deposits round the smaller arteries also occur. The brain substance may be affected by means of an extension of the disease from the membranes, or as the result of deficiency of blood supply. The nerve structures of the cortex are apt to degenerate in proportion to the amount of overgrowth of the neuroglia substance. The cerebral nerves and the organs of special sense may be affected symmetrically or otherwise. The nerve fibres may become atrophied and fail to perform their functions. This brief enumeration of some of the pathological data which may occur in association with syphilis ought to suffice to show that clinical effects may be produced which progress towards dementia and paralysis, and which may or may not terminate in death in two or three years from their onset.

There is much difference of opinion as to the part played by syphilis in the production of general paralysis. My experience in Bethlem leads me to believe that a large proportion of the general paralytics admitted to that hospital suffer from cerebral degeneration due to syphilitic diseases. It is well recognised that syphilis sometimes gives rise to a pseudo-progressive paralysis in which, during the early stages, the symptoms may be identical with those of so-called general paralysis; but subsequently there is an arrest or protraction of the disease in the pseudo-form, so that the patient may live for many years. It must also be remembered that sometimes patients appear to recover from syphilitic affections of the nervous system, but they subsequently relapse and suffer from cerebral symptoms which are totally different from those of their former attack. With regard to syphilis, there-

fore, I beg to submit that the transfer of the cases of cerebral syphilis to the category of syphilitic nervous affections would be an advance in the differentiation of disease, and an advantage in that it would relieve that chaotic disease general paralysis of some of the factors which serve to make it chaotic.

Apoplectic dementia usually occurs at a more advanced age than ordinary progressive paralytic dementia, and hemiplegic symptoms are more common in the former. General paralysis is also sometimes simulated by intracranial tumours, but the symptoms of the latter are seldom as diffuse and generalised. The greatest difficulty, however, is to be met with where the cerebral affections are clinically very similar to those of general paralysis, only differing from it in that the symptoms may partially or even entirely disappear. Régis says, "Some authorities who do not recognise in principle the existence of pseudo-general paralysis consider these conditions as special forms of paresis. The greater number, however, see in them only more or less exact morbid imitations of general paralysis. Substantially there is between these two ways of viewing the subject only a simple difference of the names of "special general paralysis" and "pseudo-general paralysis," all the world being in accord as to the reality of the clinical facts. The pseudo-general paralyses are, for the most part, the result either of an infection (syphilitic pseudo-general paralysis) or of an intoxication (alcoholic saturnine, etc.). The clinical picture may be more or less identical; it is often of such a character that any symptomatic diagnosis is impracticable from the beginning. Thus it is certainly not from the difference of the symptoms that such a distinction can be made, as many authors would seem to imply. The true distinction is, I think, only to be found in the difference of the course of prognosis, and consequently in the lesions. Pseudo-general paralysis, whether due to infection as in syphilis, or toxic as in alcoholism, has a regressive course, a relatively favourable prognosis, and is associated with comparatively curable lesions. In progressive paralytic dementia, on the other hand, we have a fatal prognosis and irremediable lesions. It follows, therefore, that the diagnosis depends essentially on the radically different evolution in the two cases.

Sunstroke.—Sometimes the symptoms found intercurrent with the sopor and coma following the shock of sunstroke may take the form of delirium or of excitement with

hallucinations, passing into a condition somewhat similar to that of primary dementia. As a general rule, however, although there may be some trace left of the primary injury to the brain, the progress of the case is more favourable than when the psychosis develops some months, or even years, after the injury. Epilepsy is one of the most common of the sequelæ of sunstroke, and occurs in various degrees of severity, from slight epileptiform convulsions to the severest forms of the disease. Dr. Mickle appears to believe that the apoplectiform seizure or the epileptiform *petit mal* of general paralysis has been mistaken for sunstroke. While acknowledging that such an error may possibly occur, I stated some years ago, and from an analysis of 55 cases of insanity following sunstroke, that it would appear to be more common for the sequelæ of sunstroke to be mistaken for general paralysis.

Dr. Mickle also believes that sunstroke is not uncommonly a cause of general paralysis. On careful analysis of the cases above mentioned I was able to find only one case in which general paralysis really existed, whereas the number that simulated that affection was remarkable. In fourteen cases I found associated mental and physical defects which rendered a diagnosis extremely difficult. The physical symptoms consisted in tongue tremors, pupillar anomalies, altered reflexes, shaky and interrupted handwriting, tottering or weak gait, loss of control over the bladder and rectum, hallucinations or perversions of some or all of the senses, and mental affections such as melancholia or hypochondriasis, but more commonly exaltation, extravagance, excitement, or even acute mania. With such a combination of symptoms the diagnosis of general paralysis appeared to be warrantable, but the cases proved to be deceptive, for after a time the physical signs disappeared, and the patient recovered mentally, or the mental health remained in a weak and permanently impaired condition, as shown by some irrelevancy or inattentiveness, or more commonly by some obstinate or permanent traces of exaltation or by fixed delusions, with a bland, self-satisfied manner. Such patients become docile, cheerful, tractable, and industrious, and perhaps able to resume work, and so they may go on for years, with no marked change mentally from year to year.

The symptoms arising from locomotor ataxia, various paralyzes (either diffused or circumscribed), epilepsy, senile dementia, and many other conditions may, in some particulars, render the diagnosis difficult, but the greatest

difficulty is experienced with such affections as progressive paralytic dementia, syphilitic disease of the brain and membranes, alcoholic degeneration and dementia, with paralysis from local lesions, or circumscribed brain lesions, with dementia and paralysis (from softening, from hæmorrhage, embolism, or thrombosis).

In conclusion, gentlemen, I would submit, with all due deference to the various learned authorities upon this intricate subject, two points for consideration, viz.:—

(1.) Whether the term general paralysis is entirely satisfactory, and not merely a term having, at least in some hands, convenience as its chief recommendation. I, for my part, regard the term as applicable theoretically to a certain number of cases only, and possibly its practical application to these cases may still be deemed advisable. If, as an alternative, it may be thought better to adopt such terms as progressive paralytic dementia, and to differentiate the varieties of this affection, my remarks may have been of some slight use. If not, they are premature, and not likely to prove beneficial.

(2.) Whether by viewing general paralysis as an entity, or whether by differentiation and undermining the fort with a view to later storming, we shall be the better able at least to avoid the danger of false prediction as to the course of the disease. Numerous instances occur in which questions of the administration of property are dependent upon the recognition of the probable course and duration of the disorder. I for my part believe that the “glorious uncertainties” of the disease will gradually disappear as we succeed in limiting and defining its numerous contents.

On the Increase of Insanity, and the Boarding-out System.
By Dr. J. BRESLER, Freiburg in Silesia.

Public opinion will have it that this is a neurotic age, and that insanity is increasing year by year. The facts which have called forth this opinion, and appear to confirm it, are not by any means flattering to our civilisation or to the resistive power of latter-day humanity. The multiplication of asylums, and the numerical increase of the insane written large on the statistical returns of every civilised country during the past decade, apparently admit of no dubiety in regard to this question. It is necessary, therefore, that we

should scan these facts more closely, and thus endeavour to ascertain if the increase of lunacy is real or assumed.

In England, where the statistics of lunacy have been collected with the greatest accuracy for the last half century, in 1859 there were 18 lunatics per 10,000 inhabitants, a proportion which had risen to 30 per 10,000 in 1892. In 1869 there were four persons admitted to asylums per 10,000, compared with six in 1892. A retrospect of the history of lunacy during the last hundred years enables us to set a proper value on these comparative figures.

Just as the word *crazed* (*verrückt*) still remains a common term of contempt, so, until the beginning of the nineteenth century, there was in regard to insanity a prevalent feeling of horror or scorn, unalleviated by sympathy or the true idea of mental disease. Those of the insane who were not considered dangerous served as a sport to mischievous children or suffered from the thoughtless brutality of their elders. Those who were evidently dangerous were credited with *malice prepense*, were scourged, fettered, and maltreated. In the madhouses they fared even worse than criminals did in the gaols. A new field of activity was opened up for humane effort by the exertions of men who had awakened to a more correct knowledge of what were the underlying truths of insanity. Prejudice has been so far overcome that asylums are now recognised as hospitals for the special treatment of mental diseases, and their population is no longer entirely composed of those whose malady has brought them into conflict with the criminal law. They contain inmates who have been brought for treatment—those who formerly escaped statistical numeration. The increase, therefore, is merely a record of the statistical material brought under review, and by no means a record of the absolute number of insane. Similarly, we note the influence of modern ideas on the guardians of the poor. The guiding principle of treatment in former times was to render the dangerous harmless, now the rule is to protect the helpless. It may be stated generally that 60 per cent. of all lunatics require to be segregated in asylums, because of their constituting a danger to public safety, order, and morality. The remaining 40 per cent. are similarly detained because they would be at serious disadvantage in the outer world. The number of patients committed to asylums has, therefore, increased enormously of late years, and new asylums have become necessary in proportion. This is true of all civilised coun-

tries, although there are notable differences in detail. In England, for instance, 90 per cent. of all lunatics and idiots are cared for in asylums, whereas in East Germany the percentage does not rise to more than 30. A study of the English statistics satisfies me that the figures applicable to recent years show a certain stability in the number of the insane. It could not well be otherwise with such a high percentage under care, and an up-to-date medico-psychology apparently meeting every need.

The diminished mortality of modern asylums also contributes to this apparent increase. The length of residence is greatly prolonged, and it is by no means uncommon to find patients who have lived for 40 or even 50 years in one asylum. What untold conflicts would such patients have to endure if exposed to the fierce battle of life, even if they were able to gain a bare subsistence! How often did they perish in bygone days when uncared for and therefore lost to statistical inquiry!

Another point on which one must lay some stress is the greater care exercised in home life, owing to the recognition of the fact that certain nervous disorders are communicable. To take an instance, chorea or hysteria occurring in one member of a family exposes the others to risks of what has been called "psychical infection." Their segregation is demanded, and although they may be only on the border line of insanity, their maladies bring them under statistical review.

I conclude, then, that experience teaches that there is no increased diffusion of mental diseases, no greater tendency towards insanity, no incipient degeneration of the civilised races. I rather believe that we have evidence in this apparent increase of a higher appreciation of the truth as regards psychical disorders, and a progressive advance in the humane treatment of suffering mankind; and, therefore, a forward stride in the march of civilisation which is by no means to be despised.

While this is generally true, we are, unfortunately, not arrived at such a pitch of perfection as is eminently desirable. The scandals connected with the treatment of patients in the Mariaberg Monastery demand, and have received, public attention. A stern demand for reform has been made, and it is only too evident that reform is still urgently required in such an institution. The manner in which insane patients are treated is an affair for their sane fellow creatures. It is

a plain duty to render their unfortunate lot as endurable as possible. It is now generally admitted, notwithstanding the stigma of the Mariaberg affair, that a benefit has been conferred on an insane patient when he is placed in a properly conducted asylum, although thereby he is robbed of freedom, his dearest possession. To restore this freedom is the ideal of modern psychiatry. We are desirous of leading back to a life of freedom even those whom medical science has deemed incurable, still more those who may yet be restored to health.

Man accomplishes most in a state of freedom. An insane patient thus regains his social feeling of responsibility, the feeling that as a member of the human family he has rights and duties. During long residence within an asylum his self-consciousness, which may have become weaker owing to contact with degraded patients, or to a condition of anxious excitement, assumes its proper condition once more when he is restored to the cheerful stream of sane life. The monotonous surroundings of an institution are exchanged for a more natural *entourage*, and there may be a joyful re-awakening of early memories, sensations and inclinations. Employment and the feeling of usefulness encourages an interest in the proceedings of the outer world. The endeavour to restore all this to insane patients found its realisation when it was resolved to place them in family care under conscientious and responsible guardians and efficient medical control.

The oldest colony of the insane is at Gheel, in Belgium, where tradition relates that for many hundred years St. Dymphna conferred recovery on the insane brought to her shrine. In the year 1850 this colony was placed under medical supervision, and now receives some 1,900 patients. It must be allowed that the aggregation of so many patients is a serious defect in a system which otherwise presents many features of excellence.

In Scotland *family nursing* of insane patients, in the best sense of the term, deserves its name. The General Board of Lunacy is charged with the supervision of the insane, whether they are placed within or beyond asylums, and relative statistics have been accurately presented for a period of nearly 40 years. On the 1st January, 1894, the total number of lunatics thus reported upon in Scotland was 11,041, and of these 2,565 were boarded out in families, not including 122 on probation.

In Germany a similar system of administration has been in force for some decades, but only in localities where it has been reserved for those discharged from asylum care as not requiring such treatment any longer, and for certain cases never subjected to asylum control. Nearly all such cases are under the observation of asylum physicians, are always in contact with the asylum, and are generally lodged within the shadow of its walls.

Bremen first led the way, and imitates the Scottish system in so far that insane patients may be boarded out if they have passed a period of 14 days' observation within the local asylum. The cost amounts to 12s. to 28s. a month, as may be found appropriate in view of the mental state of each patient. There is a quadruple system of supervision; the officials of the Bremen Poor Law Authority and a medical man make frequent visits, even weekly. In this case the treatment is entrusted to the medical principal of a private retreat, and not to the asylum physician. In the neighbouring villages 47 women and 28 men were boarded out in the year 1892. The good-natured character of the simple and far from wealthy peasantry is peculiarly well adapted for the care of the insane; but there is one serious fault in the Bremen system, viz., the choice of suitable patients is made by the Poor Law Authorities and not by the physician, so that it often happens that the wrong patients are selected.

In Hanover the results of boarding out are decidedly encouraging. The Provincial Council have made it a custom to hand over suitable patients to Dr. Wahrendorf, the proprietor of the Private Asylum at Ilten, whose professional position merits the fullest confidence, who has an intimate acquaintance with the rural population about his doors. He observes the case in the asylum wards, selects a suitable guardian, superintends the subsequent treatment and the eventual discharge or re-admission of the patient. There are about 120 male patients now boarded out in the parish of Ilten, at £13 10s. per annum each. The sane population are comfortably well off and maintain an intelligent interest in the work.

Berlin introduced this method of dealing with the insane in 1885,* and there is a general consensus of opinion that, in spite of some mishaps, there is every reason to be satisfied

* See "Journal of Mental Science," Jan., 1895, article by Dr. Sibbald.

with the new departure, and to enlarge the area of its operations.

In Silesia this system has been in operation in connection with the Provincial Asylum at Bunzlau since 1886. In a neighbouring village there are 25 patients so maintained at a cost of 9½d. a day, a charge considerably less than is required for the asylum. The patients are visited every week by the physician and head attendant, their rooms are inspected, their food is weighed once a month. The results are reassuring and testify to the vitality of the boarding-out system.

In East Prussia the asylums of Allenberg and Kortau have adopted a similar plan, and have boarded out 37 and 15 patients respectively. The number of suitable cases has proved to be very small in that locality, but the system has abundantly vindicated its *raison d'être*.

I believe that there are not more than five or six patients in every hundred at present detained in German Asylums suitable for this mode of care. But although from this point of view it is not an important numerical factor, it must be observed that experience in Scotland and in Bremen shows that eventually it will assume large proportions. It must be kept in mind that the primary intention is not to relieve asylums or to attain a parsimonious economy, but rather to ensure the welfare of the patient and to advance humane principles of action. So it will remain. No doubt the wider application of this system will increase the number of lunatics reported upon by State authorities, and the cry will be raised that insanity is increasing as care and treatment improves. Just as the asylum physician is often harassed by being obliged to isolate excited patients—a system which can never be altogether departed from, although rest in bed may possibly be sometimes sufficient—so now it is the endeavour of our foremost men to extend medico-psychology across the narrow boundary of the asylum walls, and to open up the treatment of insanity to the world of humanity. To which end, indeed, a wise organisation is the first necessity.

CLINICAL NOTES AND CASES.

Notes on the Treatment of Epileptic Insanity. By Surgeon-Captain J. H. TULL WALSH, I.M.S.

During the early months of 1894 I made some rough notes on the treatment of insane patients suffering from epilepsy under my care in the Dallanda Asylum for natives of India, and it has occurred to me that the cases might be of interest in themselves, without discussion or apology for deficiencies. My notes were transcribed from the asylum records. During the years given in the tables showing relation of body weight to the number of fits per month, the cases were under my own observation. As regards any general conclusions I am convinced that in a large number of cases of insane epileptics we do not reap the same benefit from treatment by bromides, as is seen in the same number of epileptics who are not insane. At the same time the steady use of these drugs often leads to improvement in reference to the violence of the fits and the accompanying excitement, though the actual number of fits may not be in any way affected. Of the bromides, I prefer the bromide of potassium. The ammonium salt is also very useful, but I do not think that bromide of sodium is of much value. Borax has not given any satisfaction, and I have not yet tried the nitrate of silver treatment. The question of staining is not one of much importance; nitrate of silver will not materially alter the colour of a native of India. With regard to the use of sulphonal and morphia, I have found them most useful in diminishing the grave excitement often occurring before and after the epileptic attacks. The mixture given in full in the notes of Case II. is elsewhere spoken of as the "Bromide Mixture." The Table relative to each case shows, I think, that apart from excitement or intercurrent disease, the body weight is not affected by the number of fits in each month, and shows no alteration or particular improvement during the months in which no fits occurred. This Table also leads me to believe that the bromides may be taken in large doses for long periods without affecting the body weight. Symptoms of "bromidism" are but very rarely observed among the patients under treatment in the Dallanda Asylum.

CASE I.—Rhedoy Boistome, 30 years of age. Admitted into the Dallanda Asylum in July, 1870. He was then suffering from mania. He had a very severe attack of acute rheumatism in 1882. After his recovery from that illness he passed into a state of dementia. He remained quiet and “mindless,” and never showed any signs of epilepsy until the 1st of April, 1885, when he had three fits. Body weight at that time 102lbs. The next fit noted occurred in December, 1885. Early in 1886 he suffered from abscesses in the thigh and arm. In 1886 he had nine fits. In 1887 he again suffered from abscesses, but his bodily health seems to have improved; he gained weight, and in August, 1887, weighed 110lbs. He had 17 fits in 1887. In 1889 the patient had 37 fits, and became somewhat excited at the time of the paroxysms. In 1889, 19 fits; suffered from “fever,” and went down in weight to 95lbs. He does not seem to have had any special treatment for the epileptic seizures until September 1890, when he was treated with 5ss. doses of bromide of ammonium three times daily. From January to May had seven fits; May to September eight fits; September to end of year six fits. In December, 1890, the following note occurs:—“Fits less numerous; mentally the same; there is less depression and excitement after and before the fits.” In 1891 he was treated with the combined mixture of the bromides, and had only 14 fits. In 1892 the treatment was continued; the man had 22 fits. That year he suffered from an abscess of the scrotum, and his general health was poor. In 1893 all treatment was omitted; the total number of fits for ten months was only six, and during the first three months of the year he was entirely free from fits, incoherent, quiet, harmless and clean, and this result may have been due to the effect of the bromides during 1891 and 1892. In July, 1893, he had an attack of acute bronchitis, which became chronic, and did not clear up. The man died on the 29th of October, 1893. Together with the bronchitis there was considerable hypertrophy of the heart, and after a time an aortic regurgitant murmur became audible.

Post-mortem.—*Heart* large, pale, weighed 16 ounces; left ventricle hypertrophied; mitral valves normal; aortic valves incompetent and covered with ragged growths; tricuspid and pulmonary valves normal. *Lungs*: No pleuritic adhesions, cedematous; no tubercle; patches of local congestion and thickening of the small bronchi; right lung 18 ounces; left lung 16 ounces. *Liver* 48 ounces; presented a curious rounded appearance owing to the almost entire atrophy of the left lobe. The cause of this was found to be the blocking of the left common bile duct with numbers of large gall-stones (eight, from the size of a pea to that of a hazel-nut). These gall-stones must also have pressed on the blood vessels going to the left lobe. *Spleen* normal; nine ounces; preserving somewhat the early lobulated form; three lobes distinct.

Kidneys and *intestines* presented no appearance of importance. *Brain* 39 ounces; membranes much thickened and adherent to the skull; no coarse lesions in the brain substance.

CASE II.—Gurai Jena; age on admission 26 years. Admitted into the Dallanda Asylum 25th October, 1888, with a history of epilepsy for six or seven years; no cause assigned; physical condition good. In July, 1888, he killed a man by beating him with a log of wood. While in gaol he had several epileptic fits. On admission to the asylum he appeared fairly rational, but had a "semi-intoxicated look," and refused food. Before the end of the year he had 14 fits, and it does not appear from the records that he received any treatment. In 1889 he was worse; excited after the fits, then dull and silent or incoherent. When excited he was treated with morphia and sulphonal. He had 52 fits. In 1890 he was put on bromide of ammonium, 3ss. t.d. From January to September he had 31 fits, and though still incoherent and talkative at times was less excited. In September the treatment was omitted, and from then on to the end of the year he had 29 fits. Throughout 1891 he was treated with a mixture containing:—

Pot. Bromid., 3ss.

Am. Bromid., 3ss.

Pot. Iodidi, gr. iii.

Pot. Bicarb., gr. iii.

Aq. ad ʒi. Three times daily.

Towards the end of 1891 he suffered from diarrhœa, and showed signs of phthisis. He died on the 10th April, 1892. At the post-mortem examination cavities were found in both lungs. The vessels of the brain were congested, the membranes thickened, and on the posterior part of the upper surface of the hemispheres showed signs of chronic meningitis. There were no abnormal appearances in the brain substance or in the ventricles. Although treatment did not lessen the fits it appears from the monthly notes that this patient was less excited during 1891 than during the previous year.

CASE III.—Horo Koybaito, aged 36; admitted 23rd February, 1888. Period of insanity unknown, and no cause assigned. When admitted had "delusions of being followed by female evil spirits; harmless, quiet, clean, orderly." In March he had 13 fits, but was sane except at the time of the fits. In June he was losing weight, and it is stated that he was "insane for four or five days after the fits, at other times sane and cheerful." During 1888 he had 93 fits, and his mental state remained much the same. I do not find that he had any treatment. In 1889 the excitement at the time of the fits became more marked, and when the paroxysms

occurred he was treated with injections of morphia and with sulphonal, as he was "sleepless, dangerous to others, abusive." In 1889 he had 78 fits. During 1890 he was treated with the bromides of ammonium and potassium in half drachm doses three times daily, and the number of fits was reduced to 73. In 1891 the same treatment was adopted, with a further reduction of the fits to 58. In June, 1892, sodium bromide was substituted. From January to July he had 42 fits, and from July to the end of the year 44, making 86 in all. The man still continued in the same mental state, very excited before and after the fits; quiet, clean, and fairly rational in the intervals. At the end of March the bromides were omitted, and the patient took a mixture containing thirty drops of hydrobromic acid and two drops of tincture of belladonna. In addition to these drugs he was given hypodermic injections of morphia when very excited. His fits as a rule came close upon one another, and it was always necessary to confine him to his room for a few days in each month. At the end of 1893 his condition as regards the number of fits was much the same, but the excitement at the time of the fits was less marked than during the earlier years. The best gauge of improvement in that respect is, I think, the increase of body weight, as shown in the table below. There is always loss of weight where there is great excitement. The treatment adopted had no doubt much to do with cutting short the attacks of mania and minimising the evil effects which excitement has on the whole organism.

This man was quite rational at times, though slow of speech, and in one of these intervals I elicited from him that he felt an epileptic "aura" before the fits. I note this fact particularly, because it is the only record of any such preliminary sensation recognised by the patient so far as I could find out. No doubt it was present in other cases, but I could not obtain any information on the point. The same treatment, with addition of bromide of potassium occasionally in drachm doses, was continued in 1893. September, "Generally sane between the fits; is, however, excited and dangerous immediately after the fits. This case seems to have an *aura*; says he feels "something going up from his fingers." 67 fits in 1893.

CASE IV.—Shiboo Kowra, aged 32; admitted into the Dallanda Asylum 21st July, 1884. No information is given as to the cause or period of his insanity. He had threatened to kill the nuns in the Convent of St. Joseph, Chandernagore, where he was employed; he was found incapable of standing his trial owing to insanity. When admitted he was in poor general health, and showed signs of having suffered from syphilis; he was dull; stupid and incoherent; body weight, 107lbs. Up to the end of December he had 30 fits, and was treated with bromide of potassium (dose not

stated), and atropine and nitrite of amyl at the time of the epileptic attacks. He seems to have improved somewhat, and in December was "mentally coherent; rational; fits less severe;" body weight, 113lbs. In 1885 he had 96 fits, and was excited at times; body weight in December, 111lbs. He was quieter, and often sane and rational during 1886. I suppose the same treatment was continued, although there is no note to that effect. Up to August he had 65 fits, and in that month became excited and dangerous; suffered from "*ague*" in December. Total of fits, in 1886, 90. January, 1887:—"Before and after a fit of epilepsy is uncertain, incoherent, and dangerous; at other times quiet and rational." Suffered from "*ague*" in August, and lost weight; 74 fits in 1887. In 1888 was treated with "bromide of potassium, gr. xv. three times daily," and improved, going up in weight and being quieter and more free from insanity after the fits; had 62 fits, an improvement on former years, and it is noted:—December, "Does not now become insane after the fits." The patient became somewhat worse in January, 1889, but still remained less excited than in the earlier years. He improved again, remained sane, and had only 40 fits during the whole year. In 1890 the treatment was continued, sodium bromide being substituted in September for the potassium bromide. His condition improved, and he had 44 fits in all during the year; was still somewhat excited at the time of the fits, but less so than formerly, and was sane at other times. In 1891 the mixture of the bromides of ammonium and potassium was given regularly, and the fits diminished to 39 only throughout the year. He died of pneumonia in January, 1892. Weight of brain, 39 ounces; "Dura mater adherent to skull. Brain substance anæmic; a deposit of lymph on the cerebrum, cerebellum, and medulla oblongata; each lateral ventricle contained about 3iv. of sero-purulent fluid." Pneumonia and chronic pericarditis were found also.

CASE V.—Adhar Gwalla; admitted into the Dallanda Asylum from the asylum at Hazaribagh in March, 1879; age at that time, 16, and history of fits for a long time. Up to 1882 there is not much pointing to treatment in the records, so I begin his history from that year. At the commencement of that year he was dull, silent, refused food, with occasional noisy periods during the epileptic attacks. He frequently had to be fed with the stomach-pump. When excited he got injections of atropine or morphia; amount not stated, and no other notes as to treatment. In 1882 he had 103 fits. In 1883 he was still "dull, stupid, hesitating and slow in speech; refuses food; often has to be fed with the stomach-pump;" 82 fits during the year; no record of treatment. His condition remained much the same through succeeding years, and I pass on to 1888, when he first appears to have been treated

with the bromides. The following note occurs in the record for 1888:—"February 7th. Quite demented; epileptic fits very frequent; attempts to give bromide of potassium by the mouth are futile, as he invariably spits it out. He gets an occasional large dose (gr. 40) by enema. To get an enema every night at bedtime, of bromide ʒss." In that year he had between the 1st January and 7th February no less than 54 fits; from that time to the end of May 89 fits, and during the rest of the year 184 fits, making a total of 327 fits. There is nothing to show that the treatment ordered in February was pursued throughout the year. 1889, 144 fits; no record of treatment. In 1890 he was systematically treated with bromide of ammonium, and when unwilling to take medicine received it through the nasal tube without much difficulty. The dose was at first ʒss. three times daily, and this was increased to ʒi. three times daily in September of that year. Some improvement was noted, and the total number of fits was 113. In 1891 117 fits. Treatment, the bromide mixture three times daily. He was generally sullen and harmless, but dirty in habits and destructive. In 1892 treatment by bromides was stopped in April, and a hypodermic injection of morphia (gr. $\frac{1}{4}$) given when the fits appeared imminent; 129 fits. The bromides were not again given until July, 1893, but they produced no marked effect, the total number of fits being 112. He was less excited, and cleaner in habits. In April, 1894, he was demented; excited at the time of the fits, but not much.

CASE VI.—Panchoo Mundle, aged 22 years; admitted first in 1884; said to have been insane two years; cause ascribed—grief at death of his wife. Was then incoherent and had delusions; wild and violent just before, during the epileptic attacks and subsequently; 67 fits in 1885; 85 fits in 1886, mentally the same; 71 fits in 1887. In 1888 he was transferred to the asylum at Berhampur and lost sight of. Was received back in Dallanda in November, 1889. He would answer simple questions and seemed improved, but was noisy and abusive at times. 1890, January. "Excited and uncertain; throwing fæces at the warders." In March had an attack of erysipelas and lost weight considerably. June. "Excited for a few hours after a fit; between the fits is fairly rational." During 1890 he was treated, apparently for the first time, with bromides, potassium and sodium. October. "Improving, quiet after the fits;" 62 fits that year. During 1892 borax in ʒss. and ʒi. doses was substituted for the bromides and little or no difference was observed; though not quite so violent as in former years he was still uncertain after the fits. In April, 1893, the bromide treatment was omitted and morphia injected when necessary. The total number of fits during that year was 79, but the excitement was less; always weak-minded and in-

coherent. 1894. Up to the present (April) he has had $\frac{1}{50} - \frac{1}{25}$ grain nitro glycerine, t.d.s. The fits are not very numerous and he is very little excited. It has never been necessary to confine him to his room since July 1893.

CASE VII.—Ajoudhya Sheikh, age 30. Cause of insanity and duration not known; admitted 10th November, 1885. "Talks incoherently, at times very violent, excitable; so far clean; acute flexion of both knees from contractions of the skin behind the joints; probably the cicatrices are those of burns. There is a portion of unhealed cicatrix behind the right knee." In 1886 he had 36 fits, and in February was "coherent rational, sane. Generally excitable at fit times." No record of treatment. Condition in 1887 much the same; 59 fits. In 1888 he got gr. 15 of bromide of potassium twice daily. March 3rd. "Quiet, orderly, partly coherent; clean, much less excitable." September 7th. "Demented, harmless; partially coherent; still becomes excited at times, talking much, but striking no one;" 90 fits that year. During 1891 and 1892 he was systematically treated with half drachm doses of the bromides three times daily, but without reducing the number of fits; the excitement, however, was remarked to be less, and the fits were of short duration. In June, 1892, he showed signs of phthisis, from which he died. He had no fits in May, and only one from the 1st June to the time of his death. *Post-mortem*, July 23rd.—No lesions found in brain (38 ozs.) or membranes. Right lung: "Apex contained two abscess cavities about the size of a walnut, and the upper and middle lobes were in various stages of tubercular disease." Left lung "in stage of softening, and the lower lobe studded with miliary deposit." Nothing else of importance.

CASE VIII.—Nuruddin, aged 17; admitted into the Dallanda Asylum on the 20th May, 1890. The duration of his insanity was "not known," cause assigned "epilepsy." "Said to be a confirmed epileptic but not dangerous." Of his mental condition there is little or no record, but he does not appear to have been violent or excitable; at times he refused food. He had no treatment for epilepsy in 1890; 71 fits in eight months. In 1891 he remained somewhat dull, quiet and harmless, and often refused food, and had to be fed with the nasal tube. He was treated throughout the year with the bromide mixture three times daily; 87 fits. In 1892 there was no improvement visible, and he was very feeble and anæmic. He had 12 fits in January and 11 in February. Nuruddin died on the 18th February, and the following appearances were seen at the post-mortem examination:—"Body emaciated, rigor mortis well marked. *Brain and membranes*: Dura mater very adherent to cranium; membranes generally very anæmic. Brain weighed $36\frac{1}{2}$ ounces, no coarse

lesions." The other organs were apparently normal but anæmic. This seems to have been a case of congenital imbecility with epilepsy and quite unaffected by treatment.

CASE IX.--Kali Charan Mehter, aged 40, was charged with "house trespass," found incapable of making a defence owing to insanity and sent to the Dallanda Lunatic Asylum on the 30th September, 1881. He had previously been in an asylum at Berhampur. He was carefully examined by the Superintendent of the Asylum at Dallanda, and reported to be "at present loquacious when spoken to, but rational in all he says." He had six epileptic fits in October, but was not violent or excited, remained sane, and was discharged to take his trial on the 5th November. It is noticeable that no medical certificate was sent with this man to the asylum. He was readmitted to the asylum at Dallanda on the 26th November, having been acquitted on the ground of insanity. In December, 1881, Kali Charan Mehter had a febrile attack and several epileptic fits. In January, 1882, he was "possessed of delusions as to his circumstances, and in a general state of confusion." The pyrexia with some excitement continued at intervals up to June, when he was "quiet and stupid." In July he again became rational. He had 42 fits in 1882, and no treatment is mentioned except atropine used during the period of excitement in the early part of the year. In 1883 he was on the whole worse, frequently excited and dangerous, though intervals of quiet and coherence occurred; 36 fits. In 1884 variable; 25 fits. It is impossible to say what the decrease in fits was due to, as no mention is made of any treatment. 1885, 32 fits; said to be "orderly" except at fit times. 1886, 33 fits. 1887, "13th January.—After, during, and before the fits, is incoherent, excitable, abusive, and dangerous, at other times sane;" 18 fits only recorded. 1888, 20 fits; becoming more demented and less violent; still no mention of treatment. 1889, 25 fits; was apparently occasionally treated with sulphonal in 20-grain doses. "September.—Good tempered, does not get excited after fits. Rational on most subjects." In 1890 he was somewhat excited in March, and during that year was treated with bromide of ammonium gr. xx. thrice daily; he had only 17 fits. In 1891 the bromide mixture was given steadily, and he had only 9 fits, and the period of excitement after the fits was short; slightly incoherent at times, but much improved compared with previous years. In April, 1892, the bromide treatment was omitted, as there were no further signs of excitement and the fits were few. In July he had improved mentally; "no fits since April, fairly but not entirely coherent." He had 12 fits in 1892. In December of that year was "coherent and appears sane." He did not show any signs of relapse and continued sane during

the rest of his stay in the asylum, and was released in July, having had no fits for four months; in seven months he had only three fits, two in January and one in March. It would appear that this case benefited by treatment with the bromides, and the test of the improvement rests in its permanence when the treatment was discontinued.

He was discharged from the asylum on the 27th July, 1893, fairly rational and sane, so far as one could see, and free from fits. The only question which arises in this as in other cases of recovery is how far the irritation causing the epileptic seizures was affected by the bromides, and whether it would not have disappeared without treatment.

CASE X.—Chandra Dass Kaibatta, aged 30. Said to be insane since infancy; cause assigned heredity, but names of relatives not given. Admitted 20th May, 1890. Had murdered his aunt in a fit of excitement, and was charged with murder; acquitted on the grounds of insanity. On admission was partially coherent and had partial right hemiplegia, said to have existed since childhood. The fits were not very numerous, three to five or seven each month. Excitement during the epileptic period; at other times dull and depressed, generally incoherent. Put on the bromide treatment; 34 fits in eight months. No marked improvement at the end of the year. The bromide treatment was continued in 1891, and he had 45 fits and was mentally much the same. In 1892 bromide of sodium was tried from May; the average remained about the same and the total for the year was 53. Still dull and incoherent, and slightly excited after the fits. He suffered from diarrhoea, with some intermittent pyrexia, and was removed to hospital in December, 1892. Except for a short interval in December, he remained in hospital until his death. In January, 1893, the pyrexia was almost continuous, the temperature rising sometimes to 102° or 103° F. He had a dry cough and pleurisy on the right side. He died on the 30th January, 1893.

Post-mortem.—Body thin and emaciated; rigor mortis well marked.

Brain.—Regarded *in situ*, it was noticeable that the right hemisphere, and especially the anterior portion of the cerebrum, was much more developed than the left, and the anterior frontal convolutions on the left side were flattened. No other peculiarities or lesions were noted.

Thorax.—Right pleura containing pus, which seemed to have arisen in connection with several small abscesses in the right lung. Right lung contracted and hard; adherent to chest wall along the outer margin. Left lung somewhat congested, with an abscess the size of a walnut in the lower portion; not adherent,

no fluid in the pleural cavity. Other organs presented no signs of disease.

CASE XI.—Loot Behary, aged 22 years. Cause assigned for his insanity, epilepsy; said to have been insane for four years. Admitted into the Dallanda Asylum 16th February, 1889. Remarks on certificate of insanity:—"This man is subject to attacks of insanity; at present talks incessantly and incoherently. Strikes the prisoners in the police lock-up without provocation. Was in the Campbell Hospital in May, 1887, suffering from insanity. Has been arrested several times by the police as a lunatic, but as he was then harmless he was made over to his friends." During 1889 he had 44 fits up to September; was excited, but often rational. Was better towards the end of the year, and had no fits from September to the end of December. In 1890 he became sane and had no fits up to March 27th, when he left the asylum to be tried for lurking about houses at night. The man was acquitted on the grounds of insanity, and re-admitted into the asylum on the 6th May, 1890. He was put on the bromide mixture thrice daily, and had no fits up to August. He continued sane and quiet. In August he had one fit, in September 16, and then none again until December, when he had one fit. In February, 1891, was still quite sane and quiet, and was made over to his brother's care. In August, 1892, he was accused of theft and assault, and taken before the Presidency Magistrate, Calcutta. Was found incapable of making his defence, and sent to the Dallanda Asylum on the 26th August, 1892. The Superintendent noted as follows:—"This man seems for the most part to be merely weak-minded, though the history given by the police induced me to think that occasionally an acute paroxysm is superadded; is at present incoherent." In September he had 17 fits, and was very excited and violent; no fits in October, 35 in November, and 3 in December, or 55 for four months. He was treated with the bromide of sodium, $\mathfrak{z}\text{i}$. t.d.s., and hypodermic injections of morphia to control the excitement. During 1893 hydrobromic acid $\mathfrak{m}\text{x}\text{x}$. was added to his medicine, but no improvement was noted. He varied considerably; sometimes fairly sane, at others dull, and at the time of the fits excited. His excitement can be shortened by morphia. He had 86 fits in 1893 and is still in the asylum.

CASE XII.—Babloo Oram, aged 25; charged with homicide. Received from the Patua Asylum with no history, except that he was an epileptic and "violent, dangerous, and excitable." Admitted into the Dallanda Asylum 5th May, 1890. Put on the bromide mixture thrice daily. In May and June had 36 fits and 44 during the next six months, showing marked improvement as regards the monthly average. During the epileptic period was

excited and dangerous. In 1891 and 1892 the same treatment was continued, but without any very marked effect. In August and September he became very feeble after a severe attack of dysentery, and he died on the 20th September.

Post-mortem.—*Brain*: Meninges adherent to skull and thickened; a small deposit of lymph on the upper surface of the cerebrum; brain substance normal, but pale; about one ounce of serum at the base of the brain. Nothing important in the other organs. Signs of dysenteric inflammation in the intestines noted, but there do not appear to have been any ulcers.

CASE XIII.—Ananda Koormi, aged 30 years. Admitted into the Dallanda Asylum 16th August, 1884. The period of his insanity is not noted, and no cause is assigned. His general health was good; right foot deformed by an old burn. On admission was "very talkative and easily excited, ready to strike the warders." From the time of admission to the end of the year he had 46 fits; they were severe and the man was excited, uncertain, and dangerous. There was a slight improvement in 1885, the patient being quiet and coherent at times; he had 122 fits. 1886: Variable, but generally excited and dangerous to himself and others before and after the fits; 110 fits. No treatment mentioned, but appears to have been confined in "strait jacket" when excited. In succeeding years he remained much the same, with a few quiet and coherent intervals and numerous fits. In 1890 it is first recorded that he was treated with the bromide of ammonium, ʒss. t.d.s., and the number of fits registered in that year was 85. In 1891 he was put on the bromide mixture and had 98 fits. In 1892 he had 123 fits. Sodium bromide was tried, but the fits did not decrease, and in February, 1893, the bromide treatment was omitted; he had 123 fits, was always incoherent, but fairly quiet, except just before and after the fits. He is now (1894) treated with hypodermic injections of morphia when the anti-epileptic excitement is noticed, and the results are quite as good as in previous years. Nitro-glycerine was also tried for several months in this case, but without any effect.

CASE XIV.—Aman Syed Ali, aged 33; was admitted into the Dallanda Asylum in July, 1886, with acute mania of one month's duration; no cause assigned; generally "wild, dangerous, and dirty," with short intervals of quiet, when he became somewhat rational and coherent. The first epileptic fits occurred in January, 1887, and he was particularly violent when the fits came on; 19 fits during 1887 and 1888, but was often maniacal, without any actual epileptic seizures. In 1889 he was treated with bromide of potassium, morphia during the excitement, and sulphonal at night; he had very few fits—the number is not recorded. In

1890 there were only few actual epileptic convulsions, but the periods of excitement occurred at intervals of a few weeks; eight actual fits; bromide treatment (bromide mixture) continued. In 1891 34 fits, 1892 23 fits, 1893 26 fits; still dirty in habits and liable to excitement, but much less so than formerly. In 1893 the bromide mixture was omitted and morphia injections given when necessary. At the present time (April, 1894) this man is much quieter, and somewhat coherent, but still dirty in habits. Like nearly all the inmates of the asylum he is employed generally on an oil pressing mill. Employment seems to have little or no effect on the number of fits; indeed those who do light and sitting work seem to get more fits than those employed on hard work.

There is an interesting feature in this case, showing the relation between certain states of mental irritation and excitement and violent explosive conditions leading to actual fits.

CASE XV.—Hari Bagdi, aged 28; sent to the Dallanda Asylum as a “wandering lunatic” on the 2nd December, 1891. On admission he was quiet, clean in habits, and fairly coherent. No information was given as to the cause or duration of his insanity. Weight on admission 89lbs., and physical health fair. In the beginning of 1892 he was sometimes excited, abusive, and incoherent. He was treated with the bromide mixture and with cod-liver oil, and improved, becoming in November, 1892, “quiet after the fits; fairly coherent, but depressed somewhat”—71 fits. In 1893 was depressed, silly, and incoherent, with periods of excitement, without marked violence—generally once or twice a month. Treatment by the bromides was omitted in February, 1893. The fits did not increase, nor was there any marked difference; 54 fits during the year. He now (1894) only gets injections of morphia when excited. The damage done to a patient’s brain during excitement and violence must be very great, and is generally shown by some loss of bodily weight. In the Dallanda Asylum there are no padded rooms, and “restraints” are hardly ever used, since I have found that drugs are far more useful. Nitroglycerine has also been tried in this case, $\frac{1}{100}$ to $\frac{1}{50}$ grain t.d.s., without any marked effect on the fits, but it seemed to check the excitement somewhat.

CASE XVI.—Faizoo Poli, aged 23; admitted into the Dallanda Asylum on the 4th June, 1889. He was stated to have been insane for three years, and his insanity was put down to epilepsy, but no cause was suggested to account for the epilepsy. His fits were numerous, and after an attack he frequently passed into a cataleptic condition, lasting for some hours; not very excited, generally dull and heavy after the fits; at times answered simple questions fairly well. He was noticed to masturbate. In 1890 he was regularly treated with the bromide mixture. Total fits in

1890, 114. In 1891 the bromide mixture was again given regularly three times daily; fits 93. The cataleptic condition was not seen during 1891 and 1892, but the patient always became excited and dangerous at the time of the fits, and remained dull after them; he would pull out his teeth when excited. From the 9th of May, 1892, the bromides were omitted, and borax ʒi. given three times daily; the number of fits declined to 81, but the excitement and general mental condition remained much the same, and the man often attempted to injure himself by rubbing his body or striking his head against various objects, pulling his nails off, etc.; not dangerous to others. In February, 1893, this man was noticed to be very anæmic and found to have a tumour in the region of the pancreas. He was admitted to hospital, became gradually worse, and died on the 24th March. He suffered from chronic peritonitis, with a frequent rise of temperature to 100°, and on some days to 102-103°.

Post-mortem.—Body emaciated. On opening the abdomen there were signs of chronic peritonitis; straw-coloured fluid in the peritoneal cavity; deposit of old lymph over the spleen.

Heart.—Weight 6½ ounces; muscular tissue flabby and deficient in the right ventricle; valves normal.

Right Lung.—Weight 12 ounces; studded all over with very minute yellowish-white nodules, varying in size from a pin's-head to a grain of corn; these nodules were firm and hard.

Left Lung 14 ounces; nodules as in right lung.

Liver 44 ounces; capsule thickened; substance fatty and containing some 20 or 30 yellowish nodules, resembling those seen in the lungs.

Spleen 11 ounces; signs of old peritonitis on its outer aspect, and a few yellowish nodules seen.

Pancreas.—This organ weighed 45 ounces, and appeared as a large, hard lobulated mass firmly adherent to the second part of the duodenum. On cutting into this mass it appeared to be composed of large and small nodules of a yellow carcinomatous-looking growth, with a great amount of hard "pearly" fibrous tissue; there were no signs of breaking down or suppuration in any part of this growth.

Kidneys.—Right, 4 ounces; left, 4½ ounces; both apparently healthy.

Intestines pale; two ulcers running round the gut in the jejunum; a similar ulcer in the ileum. The cæcum was ulcerated and much thickened. The colon and rectum were pale, but normal.

Brain pale; no hæmorrhages or softening in any part; no tubercle; grey matter normal in quantity and apparently healthy.

The malignant growth, when examined under the microscope, was found to consist principally of fibrous tissue, with here and there collections of large round and oval cells; the ducts of the

1890.		Jan.	Feb.	March.	April.	May.	June.	July.	August.	Sept.	Oct.	Nov.	Dec.	Total
Case ii.	{ No. of fits..... { Body weight ...	2 ...	0 ...	3 111	6 ...	2 112	7 114	8 114	11 108	1 102	8 107	5 105	7 107	60
Case iv.	{ No. of fits..... { Body weight ...	6 ...	6 102	2 100	7 95 [Abscess in chest wall.]	2 99	4 101	5 98	1 104	1 103	2 103	5 105	3 106	44
Case vii.	{ No. of fits..... { Body weight ...	10 82	10 78	4 80	8 81	4 83	2 82	8 81	11 83	27 85	4 85	1 85	12 80	101
Case viii.	{ No. of fits..... { Body weight ...	...	...	...	...	1	13	8	10	8	11	6	14	71 (for 8 mos.)
Case ix.	{ No. of fits..... { Body weight ...	?	3	0	0	2	2	0	5	2	1	1	1	17 (for 11 mos.)
Case x.	{ No. of fits..... { Body weight ...	...	?	92	91	95	95	97	95	92	93	90	93	34 (for 8 mos.)
Case xi.	{ No. of fits..... { Body weight ...	0 ...	0 92	0 96	0 ...	0 93	0 98	0 96	1 95	16 94	0 95	0 92	1 94	18
Case xii.	{ No. of fits..... { Body weight ...	...	...	...	...	11	25	7	9	15	2	5	6	80 (for 8 mos.)
		...	...	...	...	111	110	100	103	102	106	96 [Very excit- ed and ab- stinent.]	98	
Case xvi.	{ No. of fits..... { Body weight ...	12 ?	10 115	5 110	11 115	5 114	15 116	9 118	15 107	7 107	7 110	11 108	6 112	114
Case i.	{ No. of fits..... { Body weight ...	1 102	2 105	1 102	0 102	0 103	0 102	0 100	3 101	0 104	4 106	2 103	1 100	14

1891.

Case ii.	{ No. of fits..... Body weight ... }	7 104	11 103	3 106	7 103	6 105	6 107	4 110	7 111	7 107	6 112	6 111	10 110	80
Case iii.	{ No. of fits..... Body weight ... }	3 125	5 119	7 118	4 127	4 129	1 128	1 123	12 120	6 123	3 122	5 123	7 125	58
Case iv.	{ No. of fits..... Body weight ... }	2 102	8 100	7 99	2 98	4 102	0 102	3 104	3 101	2 102	2 103	2 104	4 100	39
Case v.	{ No. of fits..... Body weight ... }	5 96	11 96	7 95	10 98	9 98	13 96	15 99	12 98	9 100	10 100	8 100	8 94	117
Case vi.	{ No. of fits..... Body weight ... }	5 106	5 103	3 104	3 104	4 104	1 106	6 107	9 104	7 106	8 105	5 104	6 106	62
Case vii.	{ No. of fits..... Body weight ... }	14 79	20 77	18 77	11 79	7 77	6 78	7 80	5 80	1 81	8 82	15 83	11 82	124
Case viii.	{ No. of fits..... Body weight ... }	3 75	9 74	17 72	8 75	3 77	3 76	2 79	12 77	6 82	8 82	10 83	6 83	87
Case ix.	{ No. of fits..... Body weight ... }	2 92	2 96	1 96	1 94	1 94	0 96	1 95	0 96	0 95	0 93	0 90	1 98	9
Case x.	{ No. of fits..... Body weight ... }	7 ?	2 111	1 110	4 111	5 112	2 ?	4 111	6 111	3 111	2 111	4 110	5 110	45
Case xi.	{ No. of fits..... Body weight ... }	0 92	0 ...	...	...	...	...	...	...	...	...	...	...	0 (for 2 mos.)
Case xii.	{ No. of fits..... Body weight ... }	2 97	14 92	6 100	6 100	13 102	8 106	17 104	2 102	6 103	23 102	3 103	12 103	112
Case xiii.	{ No. of fits..... Body weight ... }	12 125	17 121	10 121	9 125	4 119	2 125	3 123	9 122	4 127	14 127	6 128	8 125	98
Case xiv.	{ No. of fits..... Body weight ... }	0 125	0 128	8 125	0 129	11 129	0 130	0 129	5 129	0 129	10 132	0 129	0 129	34
Case xvi.	{ No. of fits..... Body weight ... }	7 109	20 110	6 108	8 108	4 110	8 112	6 114	9 119	5 114	7 114	9 114	4 115	93
Case xvii.	{ No. of fits..... Body weight ... }	1 ?	3 ?	2 121	5 ?	0 125	0 127	2 127	2 126	1 121	2 125	3 123	0 122	21

1891 (continued).	Jan.	Feb.	March.	April.	May.	June.	July.	August.	Sept.	Oct.	Nov.	Dec.	Total.
Case xviii.	{ No. of fits..... { Body weight ...	{ 14 129	{ 12 129	{ 9 120	{ 6 130	{ 1 131	{ 1 129	{ 2 132	{ 3 128	{ 5 127	{ 7 127	{ 5 129	68
1892.													
Case i.	{ No. of fits..... { Body weight ...	{ 1 102	{ 3 105	{ 1 99 [No cause.]	{ 0 102	{ 1 103	{ 1 102	{ 2 100	{ 1 94 [Serious abscess.]	{ 3 92	{ 6 99	{ 1 109	22
Case ii.	{ No. of fits..... { Body weight ...	{ 5 106	{ 3 103	{ Died	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	9 (for 3 mos.)
Case iii.	{ No. of fits..... { Body weight ...	{ 5 130	{ 9 132	{ 8 131	{ 9 130	{ 8 134	{ 13 133	{ 10 129	{ 6 19	{ 4 130	{ 8 132	{ 3 131	86
Case iv.	{ No. of fits..... { Body weight ...	{ Died	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	...
Case v.	{ No. of fits..... { Body weight ...	{ 5 101	{ 48 102	{ 4 99	{ 13 100	{ 5 100	{ 12 100	{ 8 104	{ 4 103	{ 4 102	{ 9 103	{ 8 104	129
Case vi.	{ No. of fits..... { Body weight ...	{ 8 104	{ 5 108	{ 4 109	{ 7 107	{ 6 110	{ 5 110	{ 4 108	{ 7 112	{ 9 112	{ 3 ...	{ 3 ...	65
Case vii.	{ No. of fits..... { Body weight ...	{ 4 80	{ 7 79	{ 9 79	{ 0 79	{ 1 76	{ Died 23rd	{ ...	{ ...	{ ...	{ ...	{ ...	29 (for 7 mos.)
Case viii.	{ No. of fits..... { Body weight ...	{ 11 80	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	{ ...	23 (for 2 mos.)
Case ix.	{ No. of fits..... { Body weight ...	{ 2 90	{ 1 94	{ 2 92	{ 0 90	{ 0 92	{ 2 94	{ 0 93	{ 5 92	{ 0 92	{ 0 91	{ 0 92	12
Case x.	{ No. of fits..... { Body weight ...	{ 8 112	{ 2 108	{ 7 112	{ 3 111	{ 3 111	{ 5 108 [Rt. fever.]	{ 3 101	{ 4 101	{ 5 101	{ 7 98	{ 1 87 [Diarrhoea.]	53

	No. of fits.....	...	...	...	...	...	...	...	...	Re-ad. 26th.	17	0	35	3	55 (for 4 mos.)
Case xi.	{ No. of fits..... { Body weight ...	...	...	...	...	...	...	...	...	95	97	97	99	96	
Case xii.	{ No. of fits..... { Body weight ...	2 105	4 102	13 102	...	5 ?	9 96	15 98	8 98	6 97	Died 90	...	...	...	...
Case xiii.	{ No. of fits..... { Body weight ...	14 120	14 125	8 121	8 125	15 125	8 125	10 121	10 123	8 125	15 126	12 124	7 124	5 122	123
Case xiv.	{ No. of fits..... { Body weight ...	0 116	0 119	0 119	7 123	0 123	0 123	0 130	12 131	4 135	0 135	0 133	0 133	0 135	23
Case xv.	{ No. of fits..... { Body weight ...	18 90	5 88	4 90	2 86	10 85	3 91	5 92	5 92	5 94	6 93	5 93	5 92	3 89	71
Case xvi.	{ No. of fits..... { Body weight ..	4 114	7 112	7 112	14 109	9 111	5 111	8 111	8 111	4 109	6 113	4 113	9 108	4 106	81
Case xvii.	{ No. of fits..... { Body weight ...	1 123	1 119	1 118	1 117	3 118	3 112	1 [Very excited.]	1 115	2 114	1 117	2 116	0 116	2 117	18
Case xviii.	{ No. of fits..... { Body weight ...	6 125	22 124	14 125	8 125	6 128	4 122	7 122	6 121	4 121	4 121	6 121	4 121	4 116	91
Case i.	{ No. of fits { Body weight ...	0 19	0 110	0 109	1 103	0 104	0 105	3 100	1 95	1 95	0 94	1 93	Died	...	6 (for 10 mos.)
Case iii.	{ No. of fits..... { Body weight ..	7 130	4 123	6 133	2 129	7 130	8 130	3 128	3 126	6 123	6 123	9 124	10 123	2 124	67
Case v.	{ No. of fits..... { Body weight ...	11 106	10 104	13 102	8 97	6 101	16 104	2 102	8 106	9 108	12 108	11 107	6 101	6 101	112
Case vi.	{ No. of fits..... { Body weight ...	2 109	15 107	6 112	4 114	9 117	7 117	3 117	7 116	3 116	3 116	11 116	6 116	6 113	[Dysentery.]

[illegible]

pancreas were either obliterated or choked with cells. How long this disease had been in progress it is impossible to say, as the man never complained, and no information as to his condition was obtainable except from objective symptoms. The stools were generally mud-colour, but no blood, or mucus, or fat was noticed; there was no albumen in the urine; no cough, and generally a fairly clean tongue. He had been losing weight gradually from October, 1892.

CASE XVII.—Madhab Behara, aged 25; admitted 23rd November, 1889; stated to have been insane 10 or 12 years; cause assigned, *ganja* smoking, but this is highly improbable. On admission was dull and could not fix his attention, though he would answer simple questions. Had epileptic fits, after which he became very excited and dangerous and struck a warder. Was fairly quiet and rational between times, but always excited and dangerous at the time of the epileptic attacks. Bodily health improved greatly, and he gained five pounds (105 to 110lbs.) before the end of the year. In 1890 he had only 10 fits, his mental condition being the same, while his body weight increased to 122lbs. in December of that year; no record of treatment. In 1891 he was put on the bromide mixture, and though he had during the year 21 fits he was much less violent, and showed no signs of excitement from April to December. He became gradually more demented, and in 1892 was "silly, silent, clean and quiet even after the fits;" the same treatment was continued, and he had 18 fits. In 1892 he had no treatment, and the total number of fits was 19. Whether treatment quelled the excitement it is hard to say, as the maniacal condition passed into one of dementia, and the result may have been due to the progress of the disease. The youth has the aspect of a congenital idiot. Since July, 1893, he has not shown signs of excitement, and has been quiet and clean in habits. He had no medical treatment during 1893.

CASE XVIII.—Khoaj Sheikh, aged 31; said to have been insane for 20 years; cause assigned epilepsy; physical condition good; said to be a confirmed epileptic, but not dangerous. Admitted into the Dallanda Asylum on the 20th May, 1890; on admission "dull and incoherent." In June he was noted as "uncertain and dangerous." From the time of admission to the end of 1890 he had 42 epileptic fits. No mention is made of any treatment. In 1891 he was treated regularly with the bromide mixture; the total number of fits was 68, giving a lower monthly average than in the previous year. He remained "excitable, irritable, incoherent, and dangerous." In April, 1892, he was "uncertain, dangerous, and dirty in habits." In May the bromides were omitted, and the patient was treated with borax, gr. three times daily. On this treatment he improved, though there was no diminution in the number of fits. In November of the same year he was "quieter now, after the fits, than previously;

clean and not dangerous." The borax treatment was continued; 91 fits. In 1893 he was generally quieter, clean, incoherent and somewhat excited once or twice—less so than in former years, and not dangerous. The borax treatment was omitted in January, 1893, and the patient had only 36 fits during the year. Up to the present date (April of 1894), he has had nine fits, and he is now clean, demented, and harmless; no excitement has been noted since December, 1893. In this particular case borax seems to have been useful, but this is the only one in which I notice any improvement after using that drug, and I am afraid we must allow a large margin for doubt.

A Case of Developmental Degenerative Insanity, with Sexual Inversion, Melancholia following Removal of Testicles, Attempted Murder and Suicide. By E. S. TALBOT, M.D., Chicago, U.S.A., and HAVELOCK ELLIS.*

On the 28th March, 1894, at noon, in the open street in Chicago, Guy T. Olmstead fired a revolver at a letter-carrier named William L. Clifford. He came up from behind and deliberately fired four shots, the first entering Clifford's loins, the other three penetrating the back of his head, so that the man fell and was supposed to be fatally wounded. Olmstead made little attempt to escape, as a crowd rushed up with the usual cry of "Lynch him!" but waved his revolver exclaiming, "I'll never be taken alive," and when a police officer disarmed him, "Don't take my gun; let me finish what I have to do." This was evidently an allusion, as will be seen later on, to an intention to destroy himself. He eagerly entered the police-van, however, to escape the threatening mob.

Olmstead, who was 30 years of age, was born near Danville, Ill., in which city he lived for many years. Both parents were born in Illinois. His father, some 20 years ago, shot and nearly killed a wealthy coal operator, induced to commit the crime, it is said, by a secret organisation of a hundred prominent citizens to whom the victim had made himself obnoxious by bringing suits against them for trivial causes. The victim became insane, but the criminal was never punished, and died a few years later (1878) at the age of 44. This man had another son who was considered peculiar. The mother is still living.

* The first-named author has supplied all the data concerning this case; the second is solely responsible for the shape they assume and for the remarks.

Guy Olmstead began to show signs of sexual perversity at the age of 12. He was seduced (we are led to believe) by a man who occupied the same bedroom. Olmstead's early history is not clear from the data to hand. It appears that he began his career as a school teacher in Connecticut, and that he there married the daughter of a prosperous farmer; but shortly after he "fell in love" with her male cousin, whom he describes as a very handsome young man. This led to a separation from his wife and he went West.

He was never considered perfectly sane, and in October, 1886, we find him in the Kankakee Insane Asylum. A report of his history here has been kindly supplied by the Superintendent, Dr. Richard Dewey. His illness was reported as of three years' duration, and caused by general ill health; heredity doubtful, habits good, occupation that of a school teacher. His condition was diagnosed as paranoia. On admission he was irritable, alternately excited and depressed.

October 26.—Fears John Faulds, the man whom his father shot.

November 30.—Seriously disturbed at night; threw things out of his window. Calls himself Wagner.

Shortly after had delusions that he was in Paris and was Napoleon.

March, 1887.—Is abusive at times, but does not long retain his spite.

June, 1887.—Sent to open ward, but not trusted there, and returned to main building.

September.—Gloomy and morose.

October.—Typhoid fever.

January, 1888.—Quiet and industrious.

March.—Excitable and irritable.

April 22.—Recovered.

August.—No delusions, but acts queerly.

December.—Quiet and industrious.

January, 1889.—Sent to open ward.

March.—Employed and in good condition.

May 16.—Went home.

At this period, and again when examined more recently, Olmstead's physical condition is described as on the whole normal and fair. Height, 5ft. 8in.; weight, 159lbs. Special senses normal; genitals abnormally small, with rudimentary penis. His head is asymmetrical, and is full at the occiput, slightly sunken at the bregma, and the forehead is low.

His cephalic index is 78—a normal index. The hair is sandy, and normal in amount over head, face, and body. His eyes are grey, small, and deep set; the zygomæ normal. The nose is large and very thin. There is arrested development of upper jaw. The ears are excessively developed and malformed. The face is very much lined, the naso-labial fissure is deeply cut, and there are well-marked horizontal wrinkles on the forehead, so that he looks at least ten years older than his actual age. The upper jaw is of partial V-shape, the lower well-developed. The teeth and their tubercles and the alveolar process are normal. The breasts are full. The body is generally well-developed; the hands and feet are large.

Olmstead's history is defective for some years after he left Kankakee. In October, 1892, we hear of him as a letter-carrier in Chicago. During the following summer he developed a passion for William Clifford, a fellow letter-carrier about his own age, also previously a school teacher, and regarded as one of the most reliable and efficient men in the service. For a time Clifford seems to have shared this passion, or to have submitted to it, but he quickly ended the relationship and urged his friend to undergo medical treatment, offering to pay expenses himself. Olmstead continued to write letters of the most passionate description to Clifford, and followed him about constantly until the latter's life was made miserable. In December, 1893, Clifford placed the letters in the postmaster's hands, and Olmstead was requested to resign at once. Olmstead complained to the Civil Service Commission at Washington that he had been dismissed without cause, and also applied for reinstatement, but without success.

In the meanwhile, apparently on the advice of friends, he went into hospital, and in the middle of February, 1894, his testicles were removed. No report from the hospital is to hand.

The effect of removing the testicles was far from beneficial, and he began to suffer from hysterical melancholia. A little later he went into hospital again. On March 19th he wrote to Dr. Talbot from the Mercy Hospital, Chicago: "I returned to Chicago last Wednesday night, but felt so miserable I concluded to enter a hospital again, and so came to Mercy, which is very good as hospitals go. But I might as well go to Hades as far as any hope of my getting well is concerned. I am utterly incorrigible, utterly incurable, and utterly impossible. At home I thought for a time that I was cured,

but I was mistaken, and after seeing Clifford last Thursday I have grown worse than ever so far as my passion for him is concerned. Heaven only knows how hard I have tried to make a decent creature out of myself, but my vileness is uncontrollable, and I might as well give up and die. I wonder if the doctors knew that after emasculation it was possible for a man to have erections, commit masturbation, and have the same passion as before. I am ashamed of myself; I hate myself; but I can't help it. I am without medicine, a big, fat, stupid creature, without health or strength, and I am disgusted with myself. I have no right to live, and I guess people have done right in abusing and condemning me. I know now that this disease was born in me, and will leave me only when my breath leaves me. And this is all the harder to bear when I think I might have been a gentleman but for this horror, which has made me attempt suicide, caused me to be incarcerated in an insane asylum three years, and resulted in my being locked up in a cell in an almshouse in Connecticut for three weeks. I have friends among nice people, play the piano, love music, books, and everything that is beautiful and elevating; yet they can't elevate me, because this load of inborn vileness drags me down and prevents my perfect enjoyment of anything. Doctors are the only ones who understand and know my helplessness before this monster. I think and worry till my brain whirls, and I can scarce refrain from crying out my troubles." This letter was written a few days before the crime was committed.

When conveyed to the police-station Olmstead completely broke down and wept bitterly, crying: "Oh! Will, Will, come to me! Why don't you kill me and let me go to him!" (At this time he supposed he had killed Clifford.) A letter was found on him, as follows: "Mercy, March 27th. To Him Who Cares to Read. Fearing that my motives in killing Clifford and myself may be misunderstood, I write this to explain the cause of this homicide and suicide. Last summer Clifford and I began a friendship which developed into love." He then recited the details of the friendship, and continued: "After playing a Liszt rhapsody for Clifford over and over, he said that when our time to die came he hoped we would die together, listening to such glorious music as that. Our time has now come to die, but death will not be accompanied by music. Clifford's love has, alas! turned to deadly hatred. For some reason Clifford suddenly

ended our relations and friendship." In his cell he behaved in a wildly excited manner, and made several attempts at suicide, so that he had to be closely watched. A few weeks' later he wrote to Dr. Talbot:—"Cook County Gaol, April 23,—I feel as though I had neglected you in not writing you in all this time, though you may not care to hear from me, as I have never done anything but trespass on your kindness. But please do me the justice of thinking that I never expected all this trouble, as I thought Will and I would be in our graves and at peace long before this. But my plans failed miserably. Poor Will was not dead, and I was grabbed before I could shoot myself. I think Will really shot himself, and feel certain others will think so too when the whole story comes out in court. I can't understand the surprise and indignation my act seemed to engender, as it was perfectly right and natural that Will and I should die together, and nobody else's business. Do you know I believe that poor boy will yet kill himself, for last November when I in my grief and anger told his relations about our marriage he was so frightened, hurt, and angry that he wanted us both to kill ourselves. I acquiesced gladly in his proposal to commit suicide, but he backed out in a day or two. I am glad now that Will is alive, and am glad that I am alive, even with the prospect of years of imprisonment before me, but which I will cheerfully endure for his sake. And yet for the last ten months his influence has so completely controlled me, both body and soul, that if I have done right he should have the credit for my good deeds, and if I have done wrong he should be blamed for the mischief, as I have not been myself at all, but a part of him, and happy to merge my individuality into his."

Olmstead was tried privately in July. No new points were brought out. He was sentenced to the Criminal Insane Asylum. Shortly afterwards, while still in the prison at Chicago, he wrote to Dr. Talbot: "As you have been interested in my case from a scientific point of view there is a little something more I might tell you about myself, but which I have withheld because I was ashamed to admit certain facts and features of my deplorable weakness. Among the few sexual perverts I have known I have noticed that all are in the habit of often closing the mouth with the lower lip protruding beyond the upper." [Usually due to arrested development of upper jaw.] "I noticed the peculiarity in Mr. Clifford before we became intimate, and

I have often caught myself at the trick. Before that operation my testicles would swell and become sore and hurt me, and have seemed to do so since, just as a man will sometimes complain that his amputated leg hurts him. Then, too, my breasts would swell, and about the nipples would become hard and sore and red. Since the operation there has never been a day that I have been free from sharp, shooting pains down the abdomen to the scrotum, being worse at the base of the penis. Now that my fate is decided I will say that really my passion for Mr. Clifford is on the wane, but I don't know whether the improvement is permanent or not. I have absolutely no passion for other men, and have begun to hope now that I can yet outlive my desire for Clifford, or at least control it. I have not yet told of this improvement in my condition, because I wished people to still think I was insane, so that I would be sure to escape being sent to the penitentiary. I know I was insane at the time I tried to kill both Clifford and myself, and feel that I don't deserve such a dreadful punishment as being sent to a States prison. However, I think it was that operation and my subsequent illness that caused my insanity rather than passion for Clifford. I should very much like to know if you really consider sexual perversion an insanity."

Remarks.—Although the history is imperfect, we may regard this man as the subject of ill-defined hereditary degeneration, taking on the symptoms of various morbid groups, but not easily falling into any definite nosological frame. The physical conformation suggests that Olmstead's sexual inversion was congenital, although this can seldom be asserted or denied with absolute assurance; he at least presented, both mentally and physically, the favourable soil which the parasitic growth of sexual inversion most easily seizes on to flourish vigorously. He was sexually ill-developed, very suggestible, and, as frequently happens with the weak, his passion was fostered by its hopelessness. At Kankakee his case was diagnosed as "paranoia." (Dr. Dewey understands by paranoia "a primary developmental insanity," a "condition of degeneracy;" "there is imbecility of mind and there are delusions.") It is quite clear that there was no fixed and systematised delusion, but merely a condition of general mental irritability and weakness, sometimes excited, sometimes depressed, sending out occasional inco-ordinated sprouts of delusion. The same feebleness and incoherence may be traced in his criminal resolution, in his

method of carrying it out, and in the letter of April 23. There was no reason why his friend should die, suicide would have amply settled the whole account; but he had persuaded himself that their lives were bound up together.

The removal of the testicles, the apparently depressing effect of the operation, and the speedy occurrence of the crime after it, should suggest caution to the surgical psychiatrists who advocate the castration of inverts and sexual perverts generally. Such persons are frequently of unstable mental balance, so that the mutilation produces a depressing effect, while it does not remove the perverted tendency.

The case has some medico-legal interest. It recalls that of Alice Mitchell, a sexually-inverted girl of neurotic stock, who, a few years ago at Memphis, U.S.A., killed her former intimate friend, Freda Ward, when the latter became engaged to be married. Inverts, in spite of a tendency to mental irritability, are capable of a considerable degree of culture, especially in an æsthetic direction; they rarely enter asylums or even seek medical advice, and they are always liable to become centres of medico-legal interest. In this case, since there was a distinct history of insanity entirely apart from the inversion, no other termination could be expected.

The presence of so-called gynæcomastia—with tendency of the breasts to swell and become hard and red—may be noted. In a slight degree this condition has been found by Moll, Laurent, and Wey among inverts who were presumably congenital. In this case it seems to be fairly well marked.

There are various minor points of interest to which it is unnecessary to call attention, but which well illustrate a certain type of sexual invert.

OCCASIONAL NOTES OF THE QUARTER.

Rest and Exercise.

We have much pleasure in submitting Professor Meyer's communication on rest and exercise in the treatment of nervous and mental diseases. That experienced observer and veteran teacher of the University of Göttingen has been an honorary member of the Medico-Psychological Association since 1867, when his name was proposed for election as the first to introduce non-restraint principles into German practice. During the thirty years which have since elapsed Professor Meyer has consistently adhered to the enlightened

ideas which he then placed in the first rank of importance, and has enriched the science of medicine with many valuable works. We, therefore, honour him as a man well qualified to speak on this cardinal point. The debate so ably sustained at the last Annual Meeting by Drs. Clouston and Batty Tuke must deeply interest every physician charged with the treatment of the insane, as a practical question which has to be solved day by day in dealing with individual cases. Professor Meyer has taken up Dr. Clouston's concluding challenge, and has shown, as the result of ripe experience, that his theory and practice go hand in hand.

It seems to us that there are two chief reasons for placing newly-admitted patients in bed. In the first place we claim that it is best for the individual patient, that we thereby attain the best results for him; and in the second place that, insanity being an affair of medicine, the most searching medical examination is a necessity. We obtain accurate information from the nursing staff; we insure opportunity for intimate and exact reports from the medical officers. It cannot be doubted that the state of secretions and excretions, the action and reaction of vital processes, the condition of the organism in detail can be more minutely and more easily investigated while the patient is segregated under special observation. To what end are hospitals being built as indispensable and valuable adjuncts to our best asylums, if they are not to be conducted upon principles which have been tested and approved by the general physician? It is surely by the irony of fate that Dr. Clouston, who has used all the weight of his wide-reaching influence in support of the hospitalisation of the insane, entered his dissent from the routine treatment of putting patients to bed for a few days or weeks—a practice which directly induces in the minds of patients and staff the idea of medical care being requisite. But Dr. Clouston fully recognises that there are cases for whom rest in bed is imperative, although he speaks strongly against the routine practice. On the other hand, we must admit that the high hopes with which the Weir Mitchell treatment was ushered in have not been sustained throughout the intervening years. We cannot but agree, with Dr. Blandford, that it has frequently proved a most conspicuous failure where it has had a fair trial. It appears to us that the balance of evidence is against it, and that Dr. Playfair's resolution not to employ it in mental cases is the outcome of untoward experience. The

limits set on the medical treatment of insane patients are, however, by far too narrow already. We are bound in honour and of necessity to welcome every new departure, and to give our best endeavours to make it a success. Massage is undoubtedly of great value in dealing with constipation, with peripheral neuritis, and other conditions encountered in our special work; and it now remains for those who have already failed, or those who have not yet attempted the Weir Mitchell treatment, to apply it to the cases indicated by Dr. Batty Tuke as promising good results.

We must, as in all controversies, be careful not to push theory to extremes and not to confuse the issues by mere words. What is wanted at this stage is a careful summarising of proved results—a statement of cases in brief detail. We have been favoured with a temperate statement of beliefs, and a discussion on the principles of treatment. Will Asylum Medical Officers now add to these a summary of precise facts?

Holloway Sanatorium.

In drawing attention to the report of the recent inquiry by the Commissioners in Lunacy on this asylum, we must reiterate the fundamental principle of the Association of which this Journal is the mouthpiece, “the improvement of the treatment of the insane.” The general good reputation of our asylums is essential to the promotion of this principle, and if any one of them becomes an object of public suspicion or distrust the others are certain to suffer.

The more thoroughly and completely, therefore, that any public imputation against an asylum is inquired into, and the more promptly this is done, the better is it for the welfare of the insane.

While it is our clear duty to endorse any criticism or censure that we consider to be just, it is also our function to protect our members from the popular prejudice against asylums, inherited from a period of general ignorance and much inhumanity.

The soundly-thinking majority of the public is educated into a knowledge of the high standard of beneficence with which our asylums are now conducted, but the lower strata of the public mind, made up of cranks and faddists, to whom everything that is wrong, and an upper stratum,

which calls itself society, ever craving for excitement or novelty, are at all times ready to have their prejudice excited by sensational allegations against asylums, published in the papers which supply news adapted to the palate of these classes.

These publications, however, must have some foundation for their attacks, and when they proceed to deliberate charges it is desirable that a responsible investigation should distinguish the basis of regrettable fact from the superstructure of exaggeration.

The Lunacy Commission, therefore, we consider has acted in the best interests of the insane in holding the inquiry to which we now draw attention, and which we print in full in *Notes and News*.

The inquiry, it will be seen, was directed generally to the "medical and other administration of the Sanatorium, and specifically to various allegations of neglect or maladministration which appeared in the pages of *Truth*."

Truth, in an article (December 19, 1895), commenting on the report, complains that it (or he) was not allowed to attend, "either personally or by deputy, to cross-examine witnesses and to state its case before the court."

The demand thus made to assume the functions of a Public Prosecutor is scarcely in keeping with the usual astuteness of this writer, and its absurdity is demonstrated if we consider that in some cases not one only, but a round dozen of newspapers might have made allegations.

Truth also expresses the belief that it could have brought before the Commissioners the persons who had given it the information on which its charges were based.

The report, however, distinctly states that the inquiry was adjourned for nearly a month in order "to communicate with the friends of the patients whose cases were the subjects of these allegations, and to invite them, if they desired it, to attend the inquiry."

The comment is obvious that to make statements in a newspaper office is one thing, to give evidence on oath in a legal inquiry is another, and that these persons by their non-attendance proved their recognition of this distinction.

The Commissioners, in their report on the inquiry, conclude that while some of the allegations, complaints, etc., "had reasonable foundation," yet "the majority" were "unfounded or resting on very slight and unimportant incidents."

They further remark that while not overlooking the very arduous task undertaken by the Superintendent in the organisation from the beginning and subsequent rapid development of the Sanatorium, they must express the opinion that the "failures and shortcomings" which have come under their notice have been due in great measure to the want of that close and unremitting personal attention on the part of the Medical Superintendent which is necessary to successful asylum management.

In the face of this censure, however modified, there can be no doubt that irregularities have occurred in the past, and it is essential that the public should be thoroughly assured that arrangements have been made to obviate their recurrence in the future. The regulations for the government of the Sanatorium, formulated by the Commissioners and the governing body, if made public would doubtless effect this object.

We refrain from detailed comment on the various allegations, etc., dealt with in the Commissioners' Report, since these matters may, to some extent, be considered still *sub judice*, it being quite possible that an attempt will be made to bring the whole matter before Parliament. The report itself will enable anyone experienced in asylum management to form a clear estimate of the value of the charges, and bears evidence to the careful inquiry and temperate judgment of its compilers.

Hack Tuke Memorial.

The Executive Committee of this fund, at a recent meeting under the presidency of Dr. Blandford, decided that the memorial should take the form of a triennial prize, to be awarded to the writer of the best essay on a given subject related to medico-psychology. The prize to be open to all competitors, without restriction in regard to nationality or profession.

The Committee further decided that the Medico-Psychological Association should be requested to undertake the carrying out of the decision of the Committee.

Several other proposals were also considered by the Committee, such as the formation of a library, etc., but there can be little question that the prize, open practically to the whole world, is thoroughly in consonance with the wide and catholic spirit of Dr. Tuke, and is, in that aspect, the most fitting form of his memorial.

The Association Library.

The donation by Mrs. Hack Tuke of more than seven hundred volumes of works on medico-psychological subjects, together with a very valuable addition from Dr. Lockhart Robertson, have led to the suggestion that these should be made the nucleus of a library, which should be accessible to all members of the Association in the United Kingdom.

To effect this object not only would arrangements have to be made for the circulation of the books, but it would be necessary that many of these should be in duplicate.

The actual cost of working would be inconsiderable, but the provision of current literature and of the back literature would involve a considerable outlay. Fortunately, the Association has a considerable reserve of funds, for which more worthy employment would be difficult to find.

Bacon says that "the best investment of a man's money is in the tools of his trade," and a good library would certainly prove a most efficient tool for the Association, and would probably attract many new members.

Dr. Outterson Wood, in his researches into the history of the Association, has discovered that the idea of a library was mooted more than fifty years ago, and is therefore in agreement with the fundamental objects of its founders.

Our members are not wanting in original practical observations on disease, but some criticism might be made on the defects in acquaintance with the past and current literature of our specialty, arising from the fact that many of our workers are isolated in country asylums and remote from access to full libraries.

The subject will probably come up for discussion at the Annual Meeting, and the best interests of the Association will be forwarded by the members treating the proposal in the most liberal spirit. If thoroughly and efficiently carried out, the study of psychological medicine in this country will most certainly be greatly advanced.

The Commissioners in Lunacy and the Lanchester Case.

In our observations on this case in the January number we observed that the Commissioners had been possibly stimulated to intervene promptly by the representations of Mr. Burns and others. This was so roundly asserted by a certain portion of the lay Press that it was accepted as a true statement.

The actual fact is that the Commissioners had visited and decided on and signed the discharge of Miss Lanchester before they were approached by Mr. Burns.

The vaunts of the Socialist Press on the influence it exerted are, therefore, without any foundation, and we can only express our regret that they found even momentary credence.

Objections to the Boarding-out System.

The boarding-out of insane persons has so long been an approved and integral part of the Scottish system of Lunacy Administration, it has been the subject of so many reports and critical examinations, that we have no intention of entering upon a disquisition as to the obvious dangers, disadvantages, and discomforts it may entail. Every good Scot accepts it as, on the whole, an eminently satisfactory solution of difficulties with which a nation is brought face to face in dealing with the mass of chronic lunacy, which as yet shows no decrease. It is a necessary part of the education of those who undertake active responsibility in this department of social work to visit, or, at least, to study the Gheel system, which is the prototype of all similar projects. In Scotland it is generally believed that the plan, so ably recommended by Sir Arthur Mitchell in his work on the *Insane in Private Dwellings* (1864), and since then so strenuously upheld year by year in the Reports of the Lunacy Board, has proved a real benefit to the insane and to the public. It is no part of that ideal to congregate the insane in particular localities, but rather to dilute the lunacy in so far as possible, just as we dilute excitement in asylum practice. Circumstances, however, have caused some neglect of this guiding principle, which it is easy to account for, and already a remedy has been applied. The decay of handloom weaving, for instance, rendered it acceptable to the numerous cottagers in Fife to supplement their diminishing incomes by receiving such cases, and, naturally, the success of neighbours in earning a welcome addition to scanty means is contagious. The Parish Council of Collessie (a rural district near Ladybank) lately met to consider this question, and their finding was that "certified lunatics in the usual way be permitted in the parish as at present." One of the ten members present entered his dissent. There seems to have

been at that meeting a general consensus of opinion that the boarded-out patients were comfortable, contented, and kindly cared for. Besides, the Inspector of Poor reported that the yearly payments made on their behalf amount to £700 or £800 a year.

The General Board of Lunacy have also considered complaints made by Mr. and Mrs. Auld, with sixteen others, to the effect that they "suffer an intolerable grievance owing to the presence of these lunatics in Collessie, feeling that neither life nor property is safe, and that freedom is most seriously and oppressively curtailed." We will not pause to reflect upon this portentous utterance, before which the parish pump must visibly pale, but only note that there is no sympathy expressed by Mr. and Mrs. Auld touching their unfortunate neighbours who are so unwelcome, no suggestion for their betterment, no desire for their freedom. "Anywhere, anywhere, out of—Collessie!" And, naturally, Mr. Labouchere is on the side of the Aulds! Not thus has improvement in the treatment of the insane been attained, not thus will it be carried to perfection. Blow hot, blow cold! Hurry every lunatic into the nearest asylum, and then—hasten to deliver him from the madhouse keeper. The Lunacy Board, however, recognising, as it has always done, that there is adequate reason to prevent the concentration of these cases, has issued a circular letter to the effect that certain parishes must not further increase the numbers of boarded-out lunatics—with such reservations as might have been expected.

No doubt the recent murder committed by William Craig gave point to the feeling which instigated the petition above mentioned. He had been boarded out for some considerable time after having passed through the Barony Parish Asylum at Lenzie, where he had been found harmless and suitable for extended liberty. Unfortunately, some little time before the fatal assault, Craig had been removed to the house of an inexperienced guardian, who apparently had not dealt with him with that amount of tact and discretion to which he had been accustomed. In a moment of anger he assaulted the wife of his guardian and her infant child, having stabbed the latter with a knife. The wounds proved fatal, and Craig was apprehended and brought before the Sheriff, who "committed him to the prison of Perth to be detained during her Majesty's pleasure." No doubt such an occurrence is of

serious moment to the lunacy authorities and to the public generally. But does it endanger the stability of the system under which Craig was cared for? During 38 years of lunacy administration in Scotland this is actually the first accident of the kind. On an average no less than 2,000 insane persons have been boarded-out yearly—that is to say as many as are contained in one of our largest asylums.

It will not be contended that one murderous assault in 38 years in such an institution, even if it only contain chronic patients, is by any means an impossibility or even likely to cause astonishment. It would appear that even the Chairman of the Portsmouth Borough Asylum is not exempt from unreasoning attack. The newspapers made this known lately under the startling head-line—*Savage Attack by a Female Lunatic*. To be sure there would have been no paragraph if it had been the ordinary occurrence of a nurse having had her face scratched. But of Portsmouth more anon!

It cannot be urged that this fatality is to constitute a sufficient reason for the reversal, or even the modification, of a policy which has contributed so efficiently to the happiness and comfort of so great a number, and which has saved the country so much money. At the same time, it certainly impresses upon over-zealous advocates of the system a caution which cannot be lightly neglected, and emphasises dangers which those charged with the selection of patients and guardians must ever be alive to.

One word as to the treatment of Craig subsequent to his appearance before the Sheriff, who, according to newspaper reports, remitted him to the Perth Prison as above indicated. It seems, however, that he was detained in Perth, but that he was replaced in the Barony Parochial Asylum, from whence he had previously been boarded-out. This is not by any means the first case of the kind, and such procedure must be watched with a jealous eye. We fully admit that crimes of violence may occur in ordinary cases of lunacy, for whom the best place is the ordinary asylum of the district; but, of late, there seems to be a tendency to limit the use of the Lunatic Department of the Perth Prison, which will, if unchecked, raise old controversies in a very acute form.

It is well known that the Perth Prison now contains but a moiety of its former population, that extravagant expenditure on Barlinnie and other prisons has proceeded apace, leaving much of the vast and expensive buildings at

Perth empty. If anything is to come of recent recommendations as to habitual offenders, Perth Prison might well be turned into a reformatory for such individuals; but in any case an attempt to depopulate the wards of the Lunatic Department and to transfer the inmates to ordinary asylums must be the signal for prompt and energetic action.*

* Since this was written another petition has been presented to the General Board of Lunacy by the proprietors and householders of the parish of Collessie. One hundred and four signatures were exhibited, but it is said that many more might have been obtained. In any case there is ample evidence of the real feeling of the neighbourhood on the statement of this overwhelming majority. The petition is in the following terms:—

To the General Board of Lunacy, Edinburgh.

Gentlemen,—Being aware that an agitation against the system of boarding-out harmless pauper lunatics in the county is being carried on by certain parties in the parish of Collessie, and that a petition has been forwarded to the General Board of Lunacy for their removal and for the abolition or curtailment of the system, we, the undersigned, proprietors and householders in the parish of Collessie, beg to subscribe to the following petition in favour of the said system, and in particular respectfully to crave that the present system be continued, and that the lunatics be allowed to remain as at present in this parish on the following grounds, and for the following among other minor reasons, viz. :—

(1) That the lunatics, in the opinion of your undersigned petitioners, are harmless and inoffensive, and are not a source of danger to life or annoyance to the great majority of residents in the neighbourhood; the fatality at the hands of one of them which took place recently in the village of Giffordtown being regarded by us as a most exceptional occurrence, and most unlikely to recur, the lunatics being under constant medical and parochial supervision.

(2) That the system is not carried on as a trade by the guardians of lunatics in this parish, the fact being that the guardians have other, though in some cases scanty, means of livelihood, and board out lunatics only to eke out to a small extent such other means.

With regard to the advantages of the system we are of opinion—

(1) That the removal of all such patients back to the asylums would enormously increase the poor rates of the county, in respect of required extra accommodation and attendance at the asylums.

(2) That the system is a means of helping many to eke out their livelihood, which in some cases would be otherwise small, and in this way also it helps to keep poor rates at a low figure.

(3) That it is at present a source of revenue to the parish of Collessie to the extent of not less than £650 per annum, the great proportion of which is spent in the parish, to the advantage of the shopkeepers, merchants, tradesmen, etc.

(4) That the system is of immense advantage to the mental health of the patients themselves, giving them as it does an idea more of home and home comforts than they could possibly get by being constantly confined in an asylum, and thereby tending in some cases to their ultimate recovery. For these and other minor reasons we respectfully subscribe to this petition.

The Appointment of Non-Specialist Asylum Superintendents.

Our contemporary the "Lancet" has a short article on the subject of the proposed appointment of a Borough Medical Officer of Health to the post of Medical Superintendent to the Borough Asylum of Portsmouth as a step of promotion. We have more than enough of the evils entailed by similar practice in America. That is not one of the things they manage better over there.

We have no intention of discussing the merits of the individual candidate in this or in any other case, but we must emphatically protest against such a procedure as unwise and mischievous.

The most able of our Superintendents will confess that even when appointed after years of experience in the specialty, they still had much to learn when they assumed the responsibility of the management of a large asylum. The more able the man the more frank will be his expression of this fact.

How much greater must be the ignorance of a man, without any experience of asylum work, suddenly relegated to a post of such heavy responsibility. He may find himself, moreover, not only ignorant of the special duties, but unfitted by his personality to discharge them with satisfaction, and although after some years of effort he may acquire experience and knowledge of his work, there can be little doubt that this must be acquired at the expense of the institution and of the patients committed to his charge.

This Association, however, is fully alive to the vast scope of medical knowledge which must be attained—the many-sided experience, the long ripening of judgment, together with the well-proven special personal aptitudes which go to the making of a competent Asylum Superintendent—and the manifest duty lies before it not only of vigorously protesting against such appointments, but of making strenuous efforts to prevent their recurrence in the future. This is imperative not only for the welfare of the insane directly, but also indirectly by its result of deterring high-class medical men from entering the specialty, to undergo the tedious training and discipline which falls to Assistant Medical Officers. Already promotion is slow and tedious.

To hold an appointment as Medical Officer of Health of districts containing 50,000 people a diploma in sanitary science, etc., is required by a legal enactment. Why should not some

special proof of efficiency be demanded from a candidate for the much more onerous post of Superintendent of an asylum for the insane?

The form such a diploma should take, and the means by which its necessity should become recognised so as to become incorporated in Lunacy Legislation, should be considered without delay, before the evil has gained additional strength by repeated precedents.

Lunacy and Breach of Promise.

It was held many years ago in the case of *Baker v. Cartwright* that a *previous* attack of insanity is not a defence to an action for breach of promise of marriage. The effect of a plea of insanity *at the time* the promise of marriage was made has curiously enough never come before the Courts for consideration till it was raised in the case of *Barnard v. Jarrard*, tried by Lord Justice A. L. Smith and a jury on February 17th last. The facts are of no legal interest. Lord Justice Smith asked the jury (1) whether the defendant was at the time when the promise was made *so* unsound of mind to the knowledge of the other party as to be legally incapable of making it (it will be observed that this is an application to promises of marriage of the law as to contracts laid down by Lord Esher in *The Imperial Loan Company v. Stone*); (2) whether the defendant was of unsound mind at the time fixed for the performance of the promise. The jury answered the first question in the negative and the second in the affirmative (assessing the damages at £500), whereupon the judge entered judgment for the defendant, no doubt on the principle that "the act of God" constitutes an exception to the rule that a person who makes an unqualified promise takes the risk of not being able to perform it. This case offers an interesting illustration of the growing tendency of the law of lunacy to group its criteria of unsoundness of mind, and thus get rid of the old objection to the "different tests of lunacy" which it adopts. In the case of contract and promise the marriage capacity to enter into the engagement and the question of notice to the other party are the material elements. In regard to wills and marriages the question of notice is immaterial—in the former case because the act is the testator's alone, in the latter because marriage is a state as well as a contract, and everything

must be presumed in favour of its validity. It need scarcely be said, however, that "notice" is of immense importance in both cases as a matter of evidence and in connection with any allegations of fraud or circumvention. Finally, the responsibility of insane persons for both matrimonial offences and crimes now appears to be governed by the rule in Macnaghten's case (see judgment of Lord Esher in *Hanbury v. Hanbury*, 1892, "Times" L. R., 560) strictly or liberally applied according to the temperament and views of the judge.

Gamble's Case.

It would have been interesting if Richard Gamble, the boy who committed the murderous outrage in Islington last autumn, and who was found unfit to plead at the Old Bailey January Sessions, had been able to take his trial. From all accounts he belonged to the class of instinctive juvenile criminals whom the law is gradually coming to recognise as proper objects not for punishment, but for treatment in asylums, and any fresh precedent which might have strengthened this growing judicial tendency would have been welcome. Its supremacy is already, however, in all probability assured. The truth is that lawyers began to be more reasonable on the subject when alienists began to reject as untenable the positive assertion of some French and American writers that there was in such cases an entire absence of any mental lesion. The result of the Plaistow case is a direct recognition of the existence of the only kind of *moral* insanity in which medical experts themselves now believe. *Apropos* of the Plaistow case, however, we view with considerable apprehension the ruling of Mr. Justice Kennedy that as Coombes was not convicted, the conviction of the man Fox as an accessory was not possible. Of course we offer no opinion as to Fox's guilt or innocence. But the learned judge's decision on this point appears to ignore the fact that lunatics *are* found guilty under the new Act, and that all that their insanity does for them is to excuse them from penal consequences. It will be a very unfortunate condition of things indeed if accessories to crimes committed by lunatics are to escape scot free. Mr. Justice Kennedy appears to have also overlooked the fact that the trial and conviction of the principal offender is not necessary

under the law as it has existed since 1861. His assumption that the conviction of the lunatic is necessary therefore rests on no better foundation than his assumption that a verdict of "guilty, but insane," is tantamount to a verdict of acquittal. It is to be hoped that there may be an early judicial revision of the Plaistow ruling.

The Attendants' Handbook.

We have received a copy of the third edition of the *Handbook for Attendants on the Insane*, published by authority of the Association. Drs. Hayes Newington and Beveridge Spence, to whom the matter was remitted, decided not to attempt a revision of the work, as the demand was so urgent and the publishers had none left in stock. They have, however, numbered the paragraphs so as to facilitate the answering of the questions to be found at the end of each chapter, and completed the book by adding the Regulations referring to the nursing examinations. As various suggestions have been made for further improvements, arrangements have been made with Messrs. Baillière, Tindall, and Cox to give timely notice when this new edition is approaching exhaustion, so that ample opportunity may be afforded for thorough revision prior to the issue of the fourth edition. Judging by past experience this will not be an affair of the dim and distant future. Meanwhile, we congratulate all concerned on the prompt appearance of this new issue in a serviceable form.

PART II.—REVIEWS.

The New Privy Council Rules.

According to the second section of the Act 30 and 31 Vic., c. 118, the Lord Lieutenant is empowered to make, by Order in Council, Rules and Regulations for the control and guidance of the officers and servants in the District Asylums of Ireland, as well as to determine the staff, appoint their salaries, and define their duties.

Accordingly from time to time a small blue-book has been issued containing the rules thus prepared, and commonly known as "the Privy Council Rules."

These rules have often been the subject of comment in our columns, and we have not been always able to express uniform approval of their provisions. So long ago as April, 1875, we said of the first two editions : " On the whole, we cannot speak very highly of the tact or wisdom shown . . . in the framing of the new Code." On the present occasion it had been understood for about two years that the Privy Council Rules were under revision, and it was hoped that the revision would be of a thorough and satisfactory character. The result, however, in the form of a new edition, dated December 17, 1894, and published in the beginning of last year, has been disappointing.

There are in the new code, as in the later editions of the old, too many survivals from an earlier day. These may be necessary for the preservation of official continuity, but they certainly impair the present efficiency of the rules. In a body of " General Rules and Regulations for the Management of District Asylums " there are some curious omissions. Thus, the duties and position of the Inspectors of Lunatics are not defined or set out, though it is evident from the numerous references to those officials that their duties in connection with asylums are very heavy and multifarious, and their responsibilities enormous. Neither is anything said about the Board of Control of Lunatic Asylums, a body which appears to exercise absolute powers over everything connected with asylum estates and asylum buildings in Ireland. Nor can it be said that these omissions are accountable from the circumstance that neither Inspectors nor Board of Control belong to the staff of any asylum, inasmuch as the first division of the rules treats of the position and duties of the Board of Governors, a body generally resembling the English or Scottish Committee. The powers of these gentlemen in Ireland seem rather limited. The Board of Control, as above mentioned, are the owners of the property and buildings, in which the Governors would appear to have only a tenants' right. The strength and the cost of the staff is determined by the Lord Lieutenant, while " no resolution of the Board of Governors affecting the discipline or management of an asylum, as established by the present rules, shall take effect, if contrary to any of them, until after it shall have been submitted, through the Inspectors, to the Chief or Under Secretary, and shall have received the approval of the Lord Lieutenant " (Rule XII.) How far-reaching this regulation

is may be seen from the fact that under these rules the duties of the gardener, the gate-keeper, the laundress, and the cook are laid down, and even the hour at which the latter important functionary is to have "everything prepared for her business" is set forth. It is difficult to see how an institution is to be managed if such details as the last mentioned, and the hour at which the night attendants are to go on duty, are dealt with in this inelastic manner.

The section dealing with the admission of patients is very complex and difficult to understand. It is much to be regretted that some method cannot be adopted in Ireland by which all public patients could be admitted to District Asylums in the same way. As a matter of fact, most cases are admitted as dangerous lunatics or dangerous idiots under the terms of the Act 30 and 31 Vic., c. 118, but the method which appears to be contemplated as the ordinary or normal mode is by an application for admission made by a relative or guardian to the Board of Governors. With reference to this method, by which patients "shall be admitted," no power of refusal seems to be given to the Governors. In any case, as the Governors, save in exceptional circumstances, only meet once a month, and as the medical certificate accompanying the application probably only holds good for seven days from its date, it is evident that the Governors can rarely exercise any power in the matter. Special provision is made, however, that the Medical Officer may admit a patient "in case of urgency," pending the meeting of the Governors. It is laid down that the application form "is to be transmitted to the Resident Medical Superintendent at the time of the lunatic being sent to the Institution" (Form D). But, according to Rule XXIV., "on admission every patient shall be examined by a member of the medical staff, who shall satisfy himself of the legality and correctness of the admission form." Does this mean that he must satisfy himself that the patient is insane, thus acting as a sort of second certifying physician, or does it merely signify that he must satisfy himself of the formal correctness of the paper? Surely in either case this is not a responsibility which should be put upon him? He might be placed in a terrible dilemma if a patient was brought to the asylum whose insanity at a first interview was doubtful, or in the case of an incorrect admission form being "transmitted" to the asylum, together with a patient who was actively suicidal. In such cases he would appear not to be legally justified in taking the patient

in, and he might not be morally justified in sending him away. It is unfortunate that some mode of admission cannot be adopted in Ireland similar to the Magistrate's order in England or the Sheriff's order in Scotland, under which the Medical Officer of the Asylum would be tolerably safe.

We are inclined to think that the regulations with regard to recording the deaths of patients and disposal of the dead are capable of improvement. It is directed that notice of death in a specified form shall be sent within 48 hours to the Inspectors, to the relatives, to the Registrar of Deaths, and in certain cases to the Registrar in Lunacy. The form contains a statement of the cause of death as ascertained by post-mortem examination, but it is further provided that "Notice shall also be sent to the relations, or one of the relations aforesaid, to remove the body within three days after the date of posting of notice. If not so removed or if the body be not claimed, or if permission is given by the relation, or one of the relations aforesaid, it shall undergo a post-mortem or anatomical examination (in accordance with the Act 2 and 3 Wm. IV., cap. 75, section 7)."

There seems to be a confusion here, for the Anatomy Act says nothing about post-mortem examinations being merely intended to regulate the methods of procuring bodies for the dissecting-rooms and providing eventual interment for bodies used for anatomical purposes. It is much to be regretted that the Privy Council should have made this extraordinary mistake, and by quoting with regard to post-mortem examinations an Act of Parliament which has nothing to do with them, should have contributed to excite afresh the prejudice, already only too strong in Ireland, against autopsies. The importance of post-mortem examinations in asylums is now well recognised, and has been strongly insisted upon by the Inspectors. We are sure that if they had been consulted about this matter, they could have explained that an autopsy and an anatomical examination are totally different, and that the provisions for the burial of bodies from the dissecting-rooms in no way applies to everyday cases of post-mortem examination.

A number of new regulations, very similar to those of the English Commissioners, provide for notification to the Inspectors of the admission of patients, for the transmission to the same officers of copies of the admission orders and certificates, and also of a medical statement as to the patient's condition to be signed by a Medical Officer. There

is no provision for re-certification, which is not required by the Irish statutes. Minute and careful instructions are given as to keeping of a medical case book. A register of casualties is also provided, and a register of mechanical restraint.

A very important regulation provides that "there shall be appointed in every District Asylum in Ireland at least one Assistant Medical Officer." We are glad to learn that this rule has been regarded as mandatory, and that provision has been made, or is being made, in every asylum in Ireland to carry it out. We have no doubt that this great step is due to the influence of the Inspectors. We wish we could see their action more distinctly throughout this revised code, which in many respects seems to us to be wanting in the spirit which should influence those who compile regulations for great hospitals. We have given an example with regard to the rule about autopsies, and we think another is to be found in the following rule (XXXIX.):—The Medical Superintendent "shall within three days of the occurrence report to the Inspectors of Lunatics any injury to a patient found existing on admission, or received during residence in the asylum, any serious casualty, outbreak of zymotic or epidemic disease, or any other matter of serious importance to the welfare of the patients under his charge."

This is a purely official rule, which, as it stands, would be impossible to carry out. A "serious casualty" is certainly included in "any injury received by a patient," but so is a black eye, and it can hardly be meant that every bruise recorded in the casualty book in every asylum is to be reported to the Inspectors. How could these already over-worked gentlemen attend to their business if they had to go into the details of "every injury," &c. Again, what is an outbreak of zymotic or epidemic disease? One case of typhoid or of influenza? or three or four cases of diarrhœa? Or, what is an epidemic? The Medical Officer of Health, where notification is compulsory, requires such a notice, but he carefully states from time to time what diseases he requires to be notified, and his requirements differ with the season. Here, as elsewhere, strict regulations to meet every possible case are medically impossible, and the effort to lay down hard and fast rules, adherence to which is not feasible, tends in no way to fix responsibility, which seems to be the foremost idea in the official mind, but on the contrary is apt to conduce to a spirit of carelessness.

Altogether we think that the revised Privy Council Rules will bear further revision. We fail to see why a plan should not be adopted in Ireland similar to that existing in England, by which all matters not dealt with by statute or by the Commissioners' (Inspectors') regulations, and all matters connected with internal discipline should be regulated by a separate code of rules for each asylum, such code to receive the sanction of the Lord Lieutenant, as the English codes receive the sanction of the Home Secretary. It is impossible to deal fully and fairly with all the requirements of some twenty-one separate institutions in a code contained in about twenty-five octavo pages, even though an effort is made to touch on everything from the admission of a patient to his burial, from the Board of Governors to the gate porter. The result must be what it is—a sketchy and uneven piece of work, too detailed in some respects and too vague in others, containing matter which might be left out, and not supplying information which might be expected. Such a code handicaps those who have to work it, whether from without or from within.

Studies in the Evolutionary Psychology of Feeling. By HIRAM M. STANLEY, Member of the American Psychological Association; pp. 390. (Swan, Sonnenschein, & Co.)

It will become obvious after perusing a very few pages of this work that the author has a theory. That theory may be described as a desire to find a more complete reference of the complex colours of emotional psychoses, from the evolutionary point of view, to hedonalgic primaries, or, to state the matter more simply, to propound a pretty complete psychology of the feelings and emotions built upon a pleasure-pain basis. Albeit many of the chapters are reproduced from periodical publications, this idea prevails throughout, and we can promise any reader specially interested in the point that it is only too diligently worked out.

In a short preface the author states himself to be well aware of the fact that he traverses the moot points in psychology—"What points," he asks, "are not moot?" and, contradicting what we have said above, adds that he himself has "*no theory* to defend," trusting, however, that the "*position* taken will receive thorough criticism." That thorough criticism which he desires, and which we think he deserves,

we are unable to give here ; but we have decided to hope that a gratifying number of readers will supply the deficiency, for we may vouchsafe the opinion at once that, from a popular point of view, it will be found difficult to dispute the impregnability of the author's main position. The vantage-ground upon which he has established himself is one of the most ancient in the universe. The question for our readers is rather whether he has so ascended it as to perceive for them in these elaborate studies a hint of any new laws of biologic evolution transcending the already confirmed groupings derived from introspection and common observation. Many—chiefly moralists and philosophers—have ascended before, and have perceived little beyond a few stupendously vague outlines ; hence, we think, the author's plaint of a "grievous lack of generally accepted results," and the remark, for example, that Professor James devotes "900 pages to the Intellect and only 100 pages each to Feeling and Will."

In discussing the phenomena of primitive individual consciousness, Mr. Stanley will be found to go far beyond the mere organic sensations mentioned by most writers on early evolution. He proceeds from sub-conscious to conscious pain ; pleasure is quite a secondary development in the struggle for life. Apropos of temperature, or any single element which can affect psychic life, he says : "The origin of pleasure is then, I think, to be traced as an intermediary feeling between pain as produced by excess and pain from lack as differentiated form." . . . A general survey from the point of view of self-conservation leads us then to regard the original psychic state as a pain-effort form. There is first a purely undifferentiated sense of pain, and closely consequent a purely undifferentiated *nisus*. There is neither sense of objectivity in general nor in any special mode, nor is there feeling of pleasure (p. 17).

Again, the author will not allow pain to be a mere reflex of the difficulty of intellectual or physiological activity. Pain arises before ideas or presentations of any kind ; it does not come from "tension," is not the reflex of "quantity of consciousness," in short, any theory of pleasure-pain depending upon other modes of consciousness is to the author (in this chapter) unsatisfactory. Without doubt he brings forward many ingenious arguments in favour of his theory—we beg pardon, his position. He tells us much which no mother of children will deny ; but when he seeks the actual

beginnings of our "mystery of pain" he approaches questions which have been more thoroughly treated by the metaphysician, and concerning which the scientific evolutionist has hitherto wisely said very little.

But as leaving in the background this question of priority, he proceeds to apply his pleasure-pain solvent to later psychic developments, his analytical and synthetical methods are so powerful that one cannot fail to become interested and to assimilate much that is useful, though with the unpleasant consciousness that his point is overstrained, and that one is wasting time over many old ideas dressed in new clothes which don't always fit. His order of procedure is as follows: First, "early differentiation," then "representation and emotion," then "fear as primitive emotion," then the "differentiation of fear," similarly followed by Despair, Anger, Surprise, Disappointment, Desire, and, in short, the whole gamut. Even the subject of education is "the art of stimulating intellectual, æsthetic, moral, and religious desires, and of providing for their progressive gratification with the best arranged and most suggestive material" (p. 224). Though while upon the subject of education one cannot help reflecting that the whole truth would include a practical demonstration of the futility and mischievousness of many other desires not included in the above category.

A powerful section is headed "Some Remarks on Attention." The author, however, tacks on his theory to his remarks, and his conclusion is that "Cognitive act as attention is always painful, and if the act of cognition is performed without pain we may promptly deny this to be an attention" (p. 250). More useful is the chapter on "Self-Feeling," which contains some rousing observations on Pride and Shame. Mr. Stanley grows so eloquent here that pleasure-pain is almost lost sight of for a brief space. The "æsthetic psychosis" is approached from first principles, and is distinguished by plain speaking. "In mankind the æsthetic feeling, as everyone may recall in his own case, arose and became prominent when near or in the teens. The rude boy and the hoyden girl then dress and adorn themselves, and a glamour of beauty is thrown about one who was once an entirely indifferent object." Or thus, with Grant Allen, "Every crow must think its own male *beautiful*." But . . . "we may take a perfectly unsexual æsthetic pleasure in long raven tresses just as we do in an ebony table; but this is obviously rather late achievement"!

A secondary development of the pleasure of the æsthetic emotions of course affords the author a handy peg for his theory, but nevertheless this chapter, which is less free from straining after originality, will be considered one of the most interesting in the book.

The one which follows, on the "Psychology of literary style," opens with a criticism of Mr. Herbert Spencer's well-known essay. The author appears to have forgotten all about his essay on "Attention" when he writes, "The pleasures of strenuous activity of attention form a certain element in literary effect . . . The pleasure of acquirement is directly as the amount of attention exercised." But he speaks to the point when he says, "Style is the man. This is the best definition of style and the best explanation of its peculiar effect. Style is expression of subjective quality. While scientist and philosopher aim to be objective, to justly reflect and interpret outward reality, the literary artist aims merely to give a perfect exposition of himself. Style is the literary expression of self-realisation. Hence the greatest stylists write to please themselves and are their own severest critics" (p. 328).

Unfortunately those rhetoricians and others who have most need of studying the "psychology of style" are the least likely to do so, though probably some among them have as little knowledge of its requisites as an ordinary performer on the trumpet has of counterpoint. The author cannot be said to be at all happy in his treatment of the "ethical emotion." He severely criticises the "golden rule," *i.e.*, "to do as we would be done by." "This is hedonistic altruism and its measure is crude and unreliable, for what might please me in a given case might not please another." Indeed hedonistic altruism, whatever its motive, has wrought both incalculable injury and unrighteousness, whether as a weak sentimentalism, as seen for instance in promiscuous charity, or in more special forms, "like parental indulgence." This is sheer nonsense, or rather pseudo-science where no science is needed. Few will agree with Mr. Stanley that this maxim, viewed in the light of its associated teachings, was ever meant to encourage selfish desires. "As others would," rightly interpreted, surely means, as they would in the light of their experience here or elsewhere, not as they would in a moment of avariciousness or undisciplined craving. Here, where if the pleasure-pain position is to yield anything of value, the form of it

ought surely to be seen, even from a scientific point of view the author's conclusions are peculiarly barren. However, as to what the inmost aim of the book has been, let the author speak for himself. "On the whole, it has been the object of our present studies to point out with some definiteness the extent and mode of the early differentiation of feeling. Owing to the peculiar difficulties which beset this form of study, and to which we have often adverted, our conclusions may seem rather meagre and uncertain, but it is sufficient if they emphasise a region of introspective study which though of the utmost practical importance, is yet the most neglected of all in psychic science; and we hope to have set forth the most probable general order of mental evolution with some distinctness as based on the struggle of existence" (p. 388). We are perhaps sufficiently qualified in the psychology of literary metaphor to see clearly what the author means by "emphasising" this region of introspection, but we must fain conclude that the reason why his harvest has been so poor is because the time was not yet come for reaping in this field. Authors have given little space because there has been little to say, nothing new to add. Mr. Stanley's work is therefore chiefly useful as a monument erected in what may freely be described as the "arctic regions" of the evolution theory, and considering the attainments and power of its author, it may well serve to remind future philosophers that until psychology has made considerable advances upon its present position it will be in vain for them to attempt to explore further. Our author was aware of the difficulty of his task and he must not be surprised if we cannot allow to him that "distinctness" of result which he seems to claim. Although these studies cannot be recommended to those who read books in order to acquire in the best possible form what is known upon a given subject, others who like to preserve records of the successes and failures of modern research, will find very good value indeed in dipping into these researches, which, at any rate, contain much powerful original thought and many valuable suggestions.

Recherches Cliniques et Thérapeutiques sur l'Epilepsie, l'Hystérie et l'Idiotie : Compte rendu du service des Enfants idiots, épileptiques, et arriérés de Bicêtre pendant l' Année, 1894. Par BOURNEVILLE, Médecin de Bicêtre, Paris, aux Bureaux du *Progrès Médical*. Pp. 141. Fig. 8. Price 5f.

This annual volume maintains the high reputation of its predecessors as a mine of information respecting the general and medical treatment of the mentally deficient children under the care of Dr. Bourneville at the Bicêtre and at the Fondation Vallée. There were at the former on the 31st December, 1894, 526 boys, and at the latter 130 girls. In addition to the usual statistical tables of admissions, discharges, and deaths, we find comprehensive synoptic tables showing the morbid conditions, the causes of death, and the post-mortem appearances in each case of decease. At the Bicêtre 18 deaths occurred, the death-rate being under 3·5 per cent.; at the Fondation Vallée the deaths were five, the rate being about 3·8 per cent. In two cases only of the 22 were autopsies omitted, in consequence of the opposition of friends; and the pathological museum of the Bicêtre is, when desirable, enriched by relics obtained (under legal authorisation) from the cemetery! A detailed list of cases discharged, and their condition on discharge, is also presented, but we miss any official summary of the total number improved, though amelioration is specifically recorded in about one-third of the cases. A certain number pass from the school to the other sections of the Bicêtre. Considering the importance which M. Bourneville rightly places upon industrial training, it would be satisfactory to learn from him the ratio of success discharged patients trained in his admirable workshops have attained in finding remunerative occupation amongst the ordinary population. It does not appear that any "Société de Patronage," such as was justly recommended by Bourneville at the Lyons Conference as indispensable for the supervision of discharged cases, at present exists.

The arrangements for education and training are described in considerable detail, not only those more immediately connected with the schoolroom, but also those regulating the animal functions, *e.g.*, digestion, respiration, and circulation. These are dealt with categorically, and under such sub-headings as Prehension of Food, Insalivation, Mastication,

Deglutition, Digestion, Defecation, and Micturition, the "education" of the last-named functions being specially dwelt upon. Baths and hydro-therapeutics also come in for a share of consideration.

A tabular statement is given of the employments at Bicêtre, consisting of joinery, tailoring, shoe making, basket making, chair-seating, brush making, and (last but not least) printing, the money value of the work of the 175 epileptic and imbecile "apprentices" being estimated at 27,588 francs, independently of garden work, in which 19 boys are engaged. The occupations of the girls are not so precisely given, but it is stated that at Vallée some of the adolescents have been utilised as "demi-infermières." Besides the medical and supervisory staff, there is at each establishment a considerable "personnel," 84 subordinates being employed at Bicêtre and 19 at Vallée. There is a large school staff, and eight masters of trades. The medical director has apparently complete control of the organisation, which is of a very efficient character.

The second part of the publication gives an account in minute detail of the method of observation and processes of examination of idiotic and backward children, and refers at some length to the discussions at the Municipal Council of Paris on the propriety of some of the proceedings resorted to by Dr. Bourneville to ascertain the physical condition and development at corresponding ages of the genital organs of the inmates of the idiot institutions and of an orphanage respectively. In the result the methods used were held to be justified on scientific grounds, but political feeling seems to have tintured the discussion with acrimony. Some practical instructions to attendants and teachers on points to be observed in the physical and mental condition of patients close this portion of the report.

The third part is clinical and pathological. It contains a fully detailed account of a case of complete congenital idiocy, with paraplegia complicated by contracture and deformation of the feet, the brain (which is figured) showing arrest of development; and a dissertation on a case of "myxœdematous idiocy," in which the autopsy revealed absence of thyroid and persistence of the anterior fontanelle at the age of 21 years.

The experience of Dr. Bourneville (as we gather from remarks elsewhere) has not been altogether favourable as to the result of thyroid treatment, which does not seem to

have been tried in the case just referred to. Some observations on the treatment of habitual drunkards, and the necessity of their being sequestered in special asylums, close the volume.

Assistance, Traitement, et Éducation des Enfants, Idiots, et Dégénérés: Rapport fait au Congrès National d'Assistance Publique (Session de Lyon, June, 1894). Par BOURNEVILLE, Médecin de Bicêtre. Paris: Bureau du Progrès Médical. Pp. 246. Fig. 28. Price 3f. 50.

In this report to a French Poor Law Conference Dr. Bourneville furnishes an elaborate account of the provision made for the care, treatment, and education of idiots and other "degenerate" children, not only in France, but in the principal European countries and in America. The information, having been compiled from schedules filled up by experts in each country, is comprehensive and up-to-date, comprising, as it does, a list both of the public and of the private establishments for mentally-deficient children. In the first chapter we find an historical sketch of hospital arrangements for this class in Paris, the presence of idiot children in the Bicêtre being traced as far back as 1750. Incidentally Dr. Bourneville regrets the non-publication in France of the reports of the Inspectors-General of Asylums, and refers to the benefit derived from the Annual Reports of the English Lunacy Commissioners. Quoting the estimate of the Inspectors that in 1874 there were 36,000 idiots and imbeciles in France, of whom 12.58 per cent. were accommodated in asylums, he gives as his own opinion that there are now 60,000 persons of all ages falling under this category. Special accommodation is provided in the Department of the Seine for about 1,000 (982) idiot and epileptic children of both sexes, the largest number (501) being at the Bicêtre under the care of Dr. Bourneville. It would appear that in the provinces generally there is but little special provision for the instruction of imbecile children, though about 800 juvenile idiots, degenerates and epileptics, are accommodated in the public asylums for the insane. In two or three instances only is there separate provision for children who would benefit by special training; but there is a scheme for the erection of an inter-departmental asylum for 500 such cases in the district of Vaucluse, the estimated

cost being 750,000 francs. So far as we can judge from the information given in the Report, the arrangements for idiots and imbeciles as distinguished from lunatics are even more inadequate in France than they are in England. In each country the metropolitan area has an admirable service; but for the provinces the provision is haphazard and casual. In England, however, we have the advantage of charitable foundations, such as Earlswood, the Royal Albert, Eastern and Western Counties Asylums, etc., which do the lion's share of the work, whereas in France everything is left to State initiative, John Bost's asylum at La Force (Dordogne) being the only considerable exception. Institutions of a private or semi-private character are said to contain 333 idiots or epileptics. Roughly we may compute as the aggregate in France not many more than 2,000 beds for idiot and epileptic children, whilst in England there is institution accommodation for 2,700 young idiots and imbeciles. Taking the estimate of Bourneville that there are 60,000 of this class of all ages in France there is special accommodation for only about three per cent., whilst if we reckon 46,000 in England and Wales we have 5.8 per cent. provided for in children's institutions, without including the asylums for adult imbeciles. Bourneville refers to complaints constantly reaching him from the departments that medical men do not know where to place idiot children: "Les hospices n'en veulent pas et les asiles non plus." He regrets that the whole matter is looked upon in France from the point of view of *police* (the sequestration of dangerous persons) rather than of *benevolence*. In his closing chapter he gives us an account of the motives which, in his opinion, justify the special care, treatment, and education of idiotic and degenerate children, referring to the economic value of relief to families, to the desirability, in view of maternal impressions and of injurious examples to brothers and sisters, of the withdrawal of such children from ordinary households, and to the necessity of their being instructed on lines distinct from those of normal primary education. He gives a formidable list of crimes committed by neglected young imbeciles—such as murder, arson, and offences against the person—which he thinks might have been avoided under a better system of care and education. Finally he refers to the obligation on the State to provide education for all its children, and points out that if children cannot be associated with others at the ordinary schools it is necessary to provide

for them elsewhere. In conclusion, Bourneville states his convictions as to modes of assistance. (1) There is a necessity for school-asylums (distinct from lunatic asylums), into which children from two years of age to 16 or 18 (or even older if immature) should be received for medico-pedagogic treatment. (2) In certain cases of backward and abnormal children resort may be had to "classes for special instruction," similar to those instituted by the London School Board. (3) Incurable idiots should be drafted to lunatic or adult imbecile asylums. (4) Cases improved by training, but not having proper home supervision, should be retained in custodial institutions, where by their labour they might contribute to their own livelihood, instead of drifting to workhouses and prisons. (5) Harmless cases might be returned to their families with a small grant towards their maintenance from *l'assistance publique*, and consequently a measure of supervision. (6) The best cases (*malades guéris*) should be encouraged to earn their living at the trades or occupations they have acquired (not necessarily escaping military service, the discipline of which may be beneficial); and for these a "Société de Patronage" (an "After-care Association") would be of value.

In the discussion which followed, the views put forward by Bourneville were generally approved; and resolutions were adopted in favour of legislative action to secure provision for idiotic and degenerate children distinct from that for the insane, and of the establishment of inter-departmental asylums, or of special departments in connection with the lunatic asylums for this category of abnormal children.

As an appendix to the report is printed a summary account of the "Medico-Pedagogic" method of treatment of idiocy, and we find presented a brief anatomo-pathological classification, a review of the pioneer efforts in the direction of the education of idiots by Itard, Voisin, and Séguin, and finally a detailed account (with illustrations) of the modes of training at present in use at the children's department of the Bicêtre. In this we trace the hand of a master of his art, and, as was observed by the President of the Conference, it may be truly said in this connection, "*Si Séguin est le premier des premiers, M. Bourneville est le premier des seconds, le premier de ceux qui après cet illustre philanthrope, se sont occupés de ces malheureux.*"

Les Lois Psychologiques du Symbolisme. Par GUILLAUME FERRERO. Paris : Alcan, 1895, pp. 249.

The name of this writer is known to many in this country in connection with various suggestive psychological speculations, and also as joint author with Lombroso of "The Female Offender." The present volume is a translation from the Italian original, revised and enlarged by the author.

Symbolism is a dangerous and complicated subject, which so easily lends itself to the vagaries of unbalanced minds, that many cautious people are apt to treat the whole subject with suspicion. It may be said at once that there is nothing whatever in this very sane and sober work to furnish examples to the student of the mattoid. Yet the book has its interest for the psychiatrist, if only by showing how deeply rooted in the human organism is the tendency to symbolism, and how easy it must ever be, by degenerative or pseudo-atavistic roads, for an enfeebled mind to slip into symbolistic ruts. The author shows, with considerable skill and great wealth of illustration, that symbolistic thought is always the easiest, and that there is a constant tendency in any of the repeated series of intelligent actions for a process of intellectual or emotional arrest to take place, and for the simplest portion of the series to remain as a routine symbol. We always seek to accomplish our ends by the least expenditure of effort, and the two psychological laws on which the author chiefly builds are those which he terms "the law of mental inertia" and "the law of least effort." The book contains chapters on mnemonic symbols, pictographic symbols, metaphorical, phonological symbols, emotional symbols, mystic symbols, etc. There is a chapter on the atavism and pathology of symbolism, and another, in conclusion, on symbolism in modern law, which, as he points out, is a veritable museum of mystic symbols. This last chapter may be regarded as an introduction to an elaborate work which the author has long been preparing on the evolution of law and justice.

Abnormal Woman. By ARTHUR MACDONALD. Washington, 1895.

The somewhat original idea has occurred to Dr. Macdonald that the "personal" advertisement columns of American newspapers might be used for purposes of sociological investigation. As such columns, he tells us,

are often put to improper uses he did not think it wrong to make them subserve scientific study, and accordingly advertised that a gentleman of high social and University position desired to enter into correspondence with a young educated woman of high social position. The results are contained in this volume, which is chiefly filled by the letters of some ninety ladies, in some cases accompanied by personal description and psycho-neural measurements by thermæsthesmometer, algometer, etc.

The book is curious and amusing, and will be read with varying degrees of sympathy, but it cannot be said that the scientific results are large. The author's previous work, "*Le Criminal Type*," is of far more solid value. Very few of the women are demonstrated to be really abnormal; as Prof. Macdonald himself admits he is dealing not so much with abnormal women as with women living under abnormal conditions. It should, however, be added that the book is intended for the general reader, and that some of the material obtained, connected with "the deeper forms of sociological abnormality," will be utilised in a future volume.

L'Année Psychologique, 1894. Par MM. BEAUNIS, BINET, RIBOT, HENRI, etc. Paris: Alcan, 1895. Pp. 619.

This volume is the first of an annual series which will be almost indispensable to those who are interested in any branch of normal or abnormal psychology. The French have not as yet made any considerable contribution to scientific psychology, but this large and extremely useful volume will do much to bring them into line with the Germans and the Americans, to whom we owe most. Simultaneously, indeed, with this volume Messrs. Macmillan have published the first part of a *Psychological Index* (in connection with the *Psychological Review*) which, as a bibliography, is of even greater value, since it contains 1,300 instead of 1,200 entries, and these are given in the original languages instead of being all translated into French. But the bibliography occupies little more than an eighth part of this volume, which has been produced by the co-operation of all the best known French psychologists, together with a few foreigners. The heaviest part of the work, however, has fallen upon Dr. Binet and M. Victor Henri, and the volume may be considered the first important contribution to science yielded by the laboratory of physiological psychology at the Sorbonne,

of which Binet is director and Henri (now attached to Wundt's laboratory at Leipzig) formerly one of his chief assistants.

The volume consists of three parts. Part I. contains original memoirs and reviews of important questions; Part II. comprises summaries of all the most important books and memoirs which have appeared during the year, classified into groups, and illustrated by diagrams etc., where necessary; Part III. is the bibliography. There is a short general introduction by Prof. Beaunis, tracing the history of psychology since its rupture with metaphysics.

Part I. begins with two studies by Binet and Henri on memory for words and memory for phrases, the influences which affect it and the nature of the errors, of which imagination is the most important; these experiments were made on some 400 Parisian school children. The study that follows, though necessarily not very precise or profound, is curiously interesting; it deals with the characteristics and methods of the chief contemporary dramatists in France, such as Sardou, Dumas, Daudet, Goncourt, Pailleron, chiefly as determined by interviews with them and by their written answers to questions; the most important contribution (occupying over fifty pages) is made by François de Curel, one of the most brilliant of the younger dramatists, who seems to possess an unusual power of self-analysis as well as an unusual willingness to open out his art-hill (as he expresses it) to the observation of science. The longest of the remaining memoirs in this part is by Prof. Delabarre, of Brown University, and contains a business-like description of the 27 American laboratories of psychology and the facilities for work they offer, with lists of the professors and teachers attached to them, and a note of the work actually done at each. Altogether, it furnishes a remarkable picture of the activity now being displayed by the Americans in every branch of experimental and applied psychology. The item of most interest to alienists is the account of the laboratory attached to McLean Hospital, the only laboratory at present in existence, except Prof. Kraepelin's at Heidelberg, in which psychiatry and experimental psychology are united. Dr. Cowles's laboratory, which contains eight rooms, is not, however, exclusively devoted to psychology (*i.e.*, clinical observations on perception, memory, association, attention, fatigue in relation to auto-intoxication, etc.); an attempt is made to combine the study of neurology, chemistry, and anatomy also, in their relation to psychology. Dr. Cowles

writes that the organisation of the laboratory was only effected with great difficulty, on account of the novelty of the effort of combining psychiatry with the other branches of medical research. "The terminal stages of mental alienation," he remarks, "must be studied as they have hitherto been, but it is necessary to add the study of the initial stages of mental disorder. To be complete, therefore, such studies must include physiological psychology, to enable us to determine the exact nature and causes of any deviation from the normal type. In the same way it is absolutely necessary to take into account all the elements comprised in mental activity and to study physiological chemistry and pathology in their relations, direct or indirect, with mental changes." There can be little doubt that this view will constantly gain ground; the study of the dead brain has its uses, but it is no longer possible to believe that it throws any great light on "mind," whether sane or insane. The reader of Prof. Delabarre's memoir must be on his guard, or he may consider that medical science plays a much larger part in American psychology than it actually does. Dr. Binet has everywhere translated "Ph. D." as "Docteur en Médecine," and only discovered the error in time to insert an erratum note; it is strange that a man of such academic distinction in his own country should be so ignorant of the academic alphabet of Germany.

Part II. is perhaps the most useful portion of the volume. It is a summary of the contents of nearly 200 of the chief books and papers published during the year on any subject relating to psychology, the analysis of the more important books being sufficiently full and careful. These summaries are divided into groups, such as Nervous Histology, Nervous Anatomy, Nervous Physiology, Perception of Light, Perception of Colours and Colour-blindness, Visual Illusions, Perception of Sounds, Sense of Direction, Coloured Hearing, Touch, Sensations of Taste and Smell, Illusions of Touch, Sense of Time and Rhythm, Attention, Association of Ideas, Memory, Illusions of Memory, Images, Pleasure and Pain, Speech, Movement, Psychometry and Psychophysics, Psychology of Children, Hypnotism, Suggestion and Hallucinations, etc. There is also a section dealing with some new instruments, and another with the obituaries of the year.

On the whole it may be repeated that this book is of the greatest value to those who wish to know what is being done in the various branches of psychology, but have no time or opportunity to search the literature of four countries.

Des Impulsions Irrésistibles des Epileptiques. Par le Dr. VICTOR PARANT. Bordeaux : Gounouilhou, Imprimeur de la Faculté de Médecine. 1895, pp. 144.

This is a report presented to the Congress of Alienists and Neurologists of France, which met at Bordeaux in August, 1895, and deals with epileptic impulses, especially from the medico-legal aspect. The monograph is divided into nine chapters, the last two of which, on the diagnosis of irresistible impulses (uncontrollable) in the epileptic, and their medico-legal relations, appeared in the "Archives Cliniques de Bordeaux" for June, 1895.

At the outset Dr. Parant draws attention to the important points which he wishes to emphasise in his study:—

1. The determination of the impulsive manifestations to which Morel gave the name of "épilepsie larvée," or masked epilepsy, the existence of which is contested by some alienists, but the reality of which seems clearly established.

2. The precision of the symptoms which, in the absence of knowledge of the existence of epileptic convulsions, enable one to refer to epilepsy the impulses which are characteristic of it.

3. The research of observations in which epileptic impulses, properly so-called, occur, in the absence of convulsive manifestations.

4. The examination of the conditions under which epileptics should be considered irresponsible for their acts, in the absence of impulses properly so-called.

While much attention has been devoted to the consideration of the various morbid manifestations of epilepsy, such as the muscular convulsions and the "mental convulsions" (epileptic furor, impulsive mania, etc.), too little has been given to the study of the habitual state of the patient, which in reality represents the effect of the chronic irritability of the nervous centres present in epilepsy. This habitual condition places the epileptic in danger of a violent outbreak on the slightest provocation, and explains many of his peculiarities of disposition and character. One might say that *ipso facto* every epileptic has tendencies to impulsiveness—medico-legally a conclusion of the utmost importance. And Féré pithily sums up the characteristics of the epileptic when he describes him as essentially mobile and explosive.

Among the impulsive conditions which may *precede* epileptic convulsions, and which are looked upon as "auræ"

by some observers, Dr. Parant dwells especially upon the motor form—"precursory epilepsy"—while on the other hand recalling the observations of Féré, Falret, Savage, etc., in which intellectual troubles (imperative ideas), attacks of mania, etc., immediately precede the convulsions.

As regards the occurrence of uncontrollable impulses during the convulsive attacks, Parant mentions such instances (Tardieu, etc.) as sudden undressing, indecent exposure, and other acts which can in no way be looked upon as the sequence of acts performed by the patient before the attack, nor as acts familiar to him. This applies to "petit mal" only, as there is no true impulsiveness during attacks of "grand mal."

Impulses consecutive to the attacks vary as regards the time of onset, and especially in their severity or gravity, and they are those which have especially attracted the attention of nearly all observers of the insane, being more marked in their duration, frequency, and intensity than the impulses which precede the attacks.

In Chapter III., dealing with masked epilepsy, Dr. Parant refers to the conflict of opinions held on the subject. There are some, on the one hand, who deny the existence of the mental condition apart from convulsive attacks, severe or slight, *i.e.*, practically denying pure "épilepsie larvée," and there are others who are content to admit the observations of Charcot, Gowers, and others, which seem to prove undoubtedly its existence. Cases of "substitution," in which a patient loses his mental troubles with the onset of epileptic attacks, or in which attacks of convulsions disappear or diminish in frequency with the onset of mental perturbation, certainly predispose one, as Dr. Parant suggests, to accept the existence of masked epilepsy. The cases quoted from Bucknill and Tuke, Sankey and Clouston, lead one irresistibly to the conclusion that certain mental conditions are in reality the psychical equivalents of epilepsy. The study of moral insanity, especially of cases which sooner or later develop convulsions, leads us also to the acceptance of the existence of a true masked epilepsy. Moreover, to refuse the diagnosis of epilepsy to a case of impulsiveness presenting all the characteristics of epileptic impulsiveness because no motor convulsions have been witnessed, nor transitory unconsciousness, is unscientific.

In dealing with the question of uncontrollable impulses in partial or Jacksonian epilepsy, Dr. Parant quotes with approval especially the observations of Professor Pitres, who

describes cases in which epileptiform attacks of a sensory, sensorial, psychical, or paralytic nature are looked upon as clinical equivalents of convulsive partial epilepsy, and in the case of the impulsive attacks consciousness is *retained*.

Chapter V. deals with the interesting subject of the association of epilepsy with alcoholism, "systematised" insanity, and various mental troubles due to degeneration. In the case of epilepsy with idiocy, it is often difficult to refer the impulsive tendencies to their true causation; in the case of other associations, with care, it is often possible to refer to each disease its special characteristics. We may even see in the same individual the association of epileptic insanity with delusional insanity and alcoholic insanity, the characteristics of each remaining often distinct.

Among the criminal and other acts which may be committed while under the influence of an epileptic impulse, Dr. Parant considers in succession attacks of violence against the person, suicide, wanderings, theft, incendiarism, and indecent behaviour, all of which exhibit more or less an element of suddenness and an absence of premeditation or consciousness.

In discussing the subject of suicide, he considers those cases of involuntary self-inflicted mutilations of the body often due to the epileptic continuing unconsciously an act begun with some dangerous instrument. In discussing impulsive vagrancy, reference is made to the interesting observations of Cabadé and Charcot, but the full history of these cases has yet to be written, for very little is known about the condition of the patients while in the automatic state, beyond that they look haggard, walk rapidly, and seem strange, according to the account of unskilled witnesses who have met them.

Among the characteristics of uncontrollable impulses in epileptics, Dr. Parant discusses their suddenness, the presence of unconsciousness during the attack, loss of memory of the attack, the similarity of successive attacks, their periodicity, etc.; although he rightly insists on the points that in some cases there may be no loss of consciousness during the attack and no amnesia after the attack, and that some of the acts accomplished by epileptics during their impulses may show premeditation, instead of being, as is usual, in contradiction to their way of thinking or acting.

In the diagnosis of uncontrollable impulses in epileptics we must consider the two conditions, either of their association with maniacal excitation, or without mania. Epileptic

furor can practically be only mistaken for transitory alcoholic mania, and in some cases the diagnosis is very difficult. In the absence of maniacal excitement, the difficulty is, not so much, knowing the signs, to affirm the diagnosis of epileptic impulsiveness, but the recognition of the signs themselves (sudden onset, loss of consciousness, amnesia, similarity of acts, etc.), especially from a medico-legal standpoint. The differential diagnosis with hysteria is, perhaps, the most important.

Medico-legally, impulsive cases requiring the greatest care, are those in which acts are accomplished which appear to be dictated by the will and show apparent premeditation, and others, in which the impulse causes the subject to consider as realised certain ideas present in the mind before the attack. Dr. Parant wisely advises us to look upon epileptics as *à priori* responsible for their acts, in the absence of distinct proofs to the contrary; the irresponsibility varies according to the individuals, and in the same individual, under different conditions. As, however, there is usually in epileptics great irritability and a tendency to violence, one often has to consider how far the will is affected, and extenuating circumstances may be urged on their behalf when a crime is committed.

In the case of epileptic criminals, sequestration is called for, but not necessarily perpetual sequestration, as a cure may take place. Before deciding to liberate an epileptic under these circumstances, however, it is wise that a long period of observation should take place, and Dr. Parant advises a consultation with several colleagues. His experience in such cases has made him particularly cautious in deciding upon the liberation of epileptics who have had uncontrollable impulses.

The monograph is an admirable *résumé* of our knowledge on the subject of epileptic impulses, and a valuable contribution to the literature of epilepsy.

Psychologische Arbeiten. Edited by EMIL KRAEPELIN.
Leipzig: Wm. Engelmann. 1895. Bd. I., Heft 1, 2, 3.

In this publication Professor Kraepelin proposes to give an account of the work done by himself and those who work under his direction. The aims and scope of this work are considered in the first article, "Der psychologische Versuch in der Psychiatrie." The scheme of work proposed in this article could not possibly be carried out by any one in-

dividual; a school of workers is necessary, and the work so far issued is evidence not only that Professor Kraepelin has formed such a school, but that it shows signs of abundant vitality. Much that this article contains has already been considered in this Journal, but all those who are interested in the scientific study of mental disease would be well repaid by reading the original.

The first "heft" contains two other articles:—

Experimentelle Studien zur Individualpsychologie. By Axel Oehrn. Pp. 92-151. This paper is chiefly useful as a comprehensive inquiry to ascertain the methods most useful for investigating the mental capacity of different individuals. The following methods were employed:—In order to study the powers of perception, counting letters singly and in groups of three, looking for and counting certain letters, and a method resembling proof reading in which the number of mistakes overlooked could be estimated; in order to study memory, learning by heart series of nonsense syllables or series of numbers; for association, addition was used; and for studying motor functions, reading aloud and writing from dictation. Each of these occupations supplied a unit, and the time taken in the performance of each unit was determined, the duration varying from .138 sec. for reading to 11.8 secs. for learning nonsense syllables. The work done by these methods in two hours was determined for ten individuals, and the result for each individual and for each kind of work expressed in the form of a curve. Attention was paid chiefly to the form of the curve which was regarded as dependent mainly on the influence of fatigue and practice. Marked differences in this form were found to exist in different individuals. Experiments were also made with two individuals to compare the capacity for work in the morning with that in the evening, the results showing a marked difference.

Ueber die Beeinflussung einfacher psychischer Vorgänge durch körperliche und geistige Arbeit. By Siegfried Bettmann. Pp. 152-208. The object of this investigation was to compare the influence on mental work of fatigue induced by mental work with that following physical exercise. The mental work used to induce fatigue was addition for one hour; the physical exercise chosen was quick walking for two hours. The forms of work examined for the influence of fatigue were:—50 choice reactions, 50 word reactions, learning series of 12 numbers by heart for half an hour,

and addition for half an hour. These four forms followed each other in this order on each day. The work of the days on which fatigue had been induced either by mental or physical work was compared with that of normal days. The most definite results were obtained from the choice reactions, partly perhaps because these immediately followed the fatiguing work. On the mental fatigue days the times for these reactions were slightly lengthened compared with the normal days; on the bodily fatigue days the times were much shorter, the shortness being due to a large proportion of premature reactions, and these days also showed an enormous increase in the number of wrong reactions (reactions with the wrong movement), reaching on one day as many as 35 per cent. The other methods showed decreased capacity for work after each kind of fatigue, and on the whole this was greater after the physical than after the mental fatigue. The conclusions drawn are that in addition to the quantitative decrease of work done after mental and bodily fatigue there is in the case of the latter a marked qualitative change due to increased motor excitability. A practical conclusion drawn is that physical exercise is not to be regarded as a means of recovery from mental fatigue.

Heft 2 and 3:—

Experimentelle Studien über Associationen. By Gustav Aschaffenburg. Pp. 209-299. This is the first part of a comprehensive study of the association of ideas, in which the normal process is considered, experiments in abnormal conditions being promised later. Three methods were employed; in one a word was given, and starting from this the subject wrote out as quickly as possible for a definite time the words which occurred to him; in the second method the first word which occurred in association with a given word was noted; the third resembled the second except that the time taken was measured, the apparatus used being Hipp's chronoscope and two lip keys.

In order to study the qualitative differences in the association process of different individuals and of the same individual under different conditions, a classification of kinds of association had to be adopted, and the author devised a scheme which resembles in general that of Wundt. The two first and chief groups in this scheme are inner and outer associations which correspond more or less closely to the more familiar associations by similarity and associations

by contiguity. The inner group comprises ideas which are co-ordinated by belonging to the same generic class or to contrasted classes, those in which the relation is that of a species to its genus and those in which there is a predicative or causal relationship. The outer group is made up chiefly of associations which depend on previous contiguity, either in space or time; of associations depending on identity of the ideas involved, or on purely verbal reminiscence. The experiments showed a slight excess of the outer over the inner group in most individuals, and the former also showed a slightly shorter duration, but the difference was not great, and was easily influenced by the nature of the words given. In another group the associations did not depend on the meaning but on the sound of the word given, including rhyming associations. These occurred with different degrees of frequency in different individuals, and when present seemed to have in several cases distinct connection with previous fatigue or emotional excitement. A fourth group comprised those in which the given word was simply repeated, those in which words previously given or associated were repeated and reactions in which no connection could be made out. In all cases the nature of the association was determined after discussion with the subject of the experiment. Other points investigated were the frequency with which the same idea recurred in association with different words, the grammatical form of the associated words, and the frequency with which the same association occurred in different individuals.

Ueber den Einfluss von Arbeitspausen auf die geistigen Leistungsfähigkeit. By Emil Amberg. Pp. 300-377. The aim of this investigation was to determine the influence of pauses of different lengths during the course of a period of mental work. The first method employed was that of addition for one hour with five minutes' pause in the middle. It was found that there was a slight increase of work done during the second half hour. In the next series each five minutes' work was followed by five minutes' pause, and it was found that in this way very little more work was done in two hours than in one hour's continuous work without pauses. A third series resembled the first, but with fifteen minutes' pause, and it was found that less work was done in the second half hour than with five minutes' pause. It may safely be assumed that the effects of fatigue disappear more in fifteen than in five minutes, and that the

prejudicial effect of the longer pause is due to some other factor. This factor has been termed by Kraepelin and Amberg "Anregung," and is regarded as analogous to the gradual overcoming of the inertia of a machine when it begins to work. It is supposed that in five minutes the effects of fatigue to some extent disappear, while the "Anregung" suffers little loss, while in fifteen minutes the greater amount of recovery from fatigue is more than counteracted by the almost complete loss of "Anregung." In the case of two hours' addition and one hour's learning by heart, the effect of fifteen minutes' pause was more favourable. The fatigue would in these cases be greater, and the recovery from fatigue in fifteen minutes would be counteracted to a less extent by the loss of "Anregung."

Other observations were made on the effect of longer pauses of seven hours and upwards without very satisfactory results. In the addition experiments the mistakes and corrections were counted and analysed, also without any very definite results. Some interesting contributions to method are made in this paper, especially in arriving at a measure of the effects of practice in order to compare with one another the work done on different days during a series affected by practice.

Ueber die Wirkung der Theebestandtheile auf körperliche und geistige Arbeit. By August Hoch and Emil Kraepelin. Pp. 378-488. The aim of this work was to determine to what extent the effect of tea on bodily and mental work depends upon the caffein and ethereal oils respectively which tea contains. In addition, the paper makes many important contributions to method. The tea oils were removed by rubbing with sugar; experiments were carried out with these oils, with caffein and with Paraguay tea, and compared with normal experiments. In the physical work, a modification of Mosso's ergograph was used, and fatigue curves after Mosso's method were observed at ten minutes' interval for an hour, the drug being usually taken after the second curve. The mental method employed was that of addition. Four individuals were tested, and part of the paper is devoted to considering the question of the individual differences which were present, not only in respect to the influence of the drugs, but in relation to the influence of practice and fatigue, and methods are given for determining the degree with which these factors come into play in

different individuals, and also at different stages in the course of an investigation.

Taking the results generally, they confirmed previous work in showing a marked favourable effect of caffein on muscular work. On the other hand the effect of the tea oils was to decrease the amount of work. The effects in Dr. Hoch's case may be seen very clearly in Table V. on page 397. The amount of work done with the ergograph depends on the extent of the individual lifts and on the number of lifts, and it was found that these behaved differently to caffein and the ethereal oils respectively; that the increase due to caffein depended on increase of height, while the decrease due to the oils depended on decrease of number of lifts. From these and other facts it is concluded that the beneficial effect of caffein on muscle work is due to direct action on the muscle substance, while the effect of the tea oils is on the central motor process. The result obtained from the method of addition differed from those with the ergograph in showing favourable influence of both caffein and the ethereal oils. The conclusion drawn is that both facilitate the process of association. During the course of the paper several other interesting questions are considered. Dr. Hoch's work showed some interesting features, which are referred to the influence of "Anregung." On examining the work at the beginning of each day of a series, it was found that the work of the first five minutes of successive days was irregular, while that of the second five minutes showed the regular increase of practice, a difference ascribed to the different amounts of inertia to be overcome on different days. The authors also believe that their experiments show an intimate relation between capacity for practice and susceptibility to fatigue; that the individual who improves rapidly by practice also tires quickly, and *vice versa*. In relation to the important question of the influence of preconceived ideas on the results, it is pointed out that in this investigation characteristic changes were produced by the drugs on the form of the fatigue curves as well as on the amount of work done, and that the former kind of change is not one which could have been foreseen.

This paper is a very important one in its development of Professor Kraepelin's methods and in the consideration of some of the practical difficulties met with in carrying out these methods, and might with advantage be read after the introductory paper in the first "Heft."

Mysophobia. By S. V. CLEVENGER, M.D., Chicago. Reprinted from the "Western Medical Reporter," November, 1894, pp. 12.

In this pamphlet an account is given of a mental affection, first described and named by Hammond, signifying fear of contamination. Dr. Clevenger has collected thirty-three cases, which have been published by various authors, some of whom consider the disease to be a tactile form of *folie du doute*, others an imperative conception, and others as a form of neurasthenia. With regard to sex, of twenty-one cases in which this is mentioned, nine were males and twelve females; of the males, five were boys at the age of puberty. The patients usually belong to the cultivated and respectable class, and thirty per cent. are considered curable. The author inclines to the *folie du doute* theory, and proceeds to relate the case of a married lady, aged 35, who had change of aversions, phthisical heredity, and unilateral tactile hallucinations and monospasm. She had always been timid as a child, but no symptom of the affection appeared until she was 18 years old, when she began to ask herself, "What if worms were in water, and I drank them, what would happen?" Later on she began to wash herself frequently to rid herself of worms and cobwebs, and burned a great quantity of clothes and table linen under the idea that these were contaminated. After an attack of tonsillitis this idea disappeared, but a woman casually mentioning that she looked consumptive, the worm idea was replaced by a fear of consumption and the abhorrence of spittle everywhere. Still later, this idea was replaced by a fear of hydrophobia, in consequence of her father having read in a newspaper that a mad dog had bitten a woman on the ankle. When she came under the author's care she sobbed hysterically, had widely dilated pupils, was careworn, pale, and with every appearance of terror, because she had seen so many dogs that day. At times she appeared improved, slept better, ate heartily, and was more cheerful, when suddenly something would occur to overwhelm her with dread lest some dog's spittle had contaminated her. She was always worse after menstruation, and had a sensation of cobwebs being spun across her face whenever a sudden aversion to an article, place, or person occurred, because they were, she thought, contaminated. In addition to the tactile hallucination of bites, she suffered at times from spasmodic contraction of the fingers, numbness

of arm, facial twitchings, and deafness on the right side, as well as from occipital headache. Intellectually she was an educated and refined woman, and an omnivorous reader. She was treated with cod-liver oil and chloralamid, as she suffered from loss of sleep, and now and then quinine. Change of scene had a beneficial effect.

The affection seems worthy of notice, and should take its place with agorophobia, claustrophobia, panophobia, and other forms of morbid fears.

Penological and Preventive Principles. By W. TALLACK.
Second Edition. London: Wertheimer and Co. Pp.
480. Price 8s.

This book has been revised and brought up to date. A considerable amount of new matter has been introduced, and some portions of the former edition omitted. The work has the merit of being impartial, and it affords a comprehensive survey of the methods employed in dealing with criminals in many lands. The author regards with extreme disfavour any form of association amongst prisoners undergoing sentence, and strongly advocates the adoption of a system of cellular confinement up to two years. Under this scheme the risk of contamination is avoided, and any ill-effects likely to arise in connection with the mental health of the prisoner are carefully safeguarded by an elaborate system of visiting, industrial occupation, instruction, and daily exercise. The plan is excellent in theory, but to those who are engaged in the daily administration of penal establishments the scheme presents so many points of practical difficulty as to render its adoption well-nigh impossible.

On the question of insanity some of the observations are very pertinent, whilst others are manifestly open to adverse criticism. No reference is made to the class of weak-minded prisoners, who require much care and attention at the hands of prison medical officers.

In Chapter V. (p. 139) some judicious remarks are to be found on the mischievous tendency displayed by magistrates and others in committing insane persons to prison instead of to lunatic asylums. The mistaken ideas of a section of the Press regarding a supposed connection between prison discipline and insanity are also sharply criticised.

The theories of Lombroso and his followers do not meet with much sympathy, but the author is evidently not quite

conversant with the trend of opinion in psychological circles in this country on the subject of criminal anthropology; he has thereby been betrayed into some looseness of expression which might have been obviated. It is stated (p. 249) that "In England a small group, popularly termed the 'mad doctors,' have propounded somewhat similar views." Who are the "mad doctors"? If by this "popular" term he means to designate those engaged in lunacy work, it is apparent that the views of such leading authorities as Dr. Maudsley and Dr. Nicolson have escaped his attention.

Regarding the defects of English law, the writer observes: "English law, by its unscientific and untrue definition of 'wilful' murder, and by its retention of capital punishment, has imported great confusion into many murder trials, and has often defeated its own object. If this law was modified, and if capital punishment was abolished, murderers, whether sane or insane, would be more readily convicted; and, provided that they were safely separated from the community, it would be of comparatively minor importance whether this was effected by a prison or an asylum." While cordially endorsing the author's opinion as to this defect in the law, we strongly object to prisons being regarded as suitable places of detention for any class of the insane.

To those who are interested in criminal life, and in the various modes employed for the deterrence of crime and the reformation of the criminal, we commend this book. It will be found valuable as a book of reference.

The Brain of the Microcephalic Idiot. By D. J. CUNNINGHAM, M.D., Professor of Anatomy, Trinity College, Dublin, and T. TELFORD SMITH, M.D., Superintendent of the Royal Albert Asylum, Lancaster. Dublin, 1895. London: Williams and Norgate.

In this paper, which is a reprint from the "Scientific Transactions" of the Royal Dublin Society, Volume v., Series II., we have a study of the brain of two interesting microcephales, one if not both of whom many of our readers have seen. The authors have made a careful study of the whole subject of microcephaly, and given their views as to its nature and origin. The first case was an idiot named Freddy Long, an inmate of the Royal Albert Asylum, where his habits were observed and his mental capacity was ascer-

tained and described by Dr. Shuttleworth. He died of phthisis in 1892 at the age of 29 years. The circumference of Freddy's head was 15 inches ; the weight of the encephalon with the membranes was 352·5 grammes. His bodily height was 56 inches. This creature had a poor intelligence, but essentially human in character. He could speak a few short words, which he always used with a meaning. He was alert and active, but made little use of his hands to do anything.

Joe was an imbecile, who was successively in the poorhouse and County Asylum at Lancaster, where he died, aged 60. He was 5ft. 9in. in height, and had the build of an English labourer. He could do rough work, and before being in the poorhouse had earned his own livelihood. From this it may be judged that he could speak and knew how to suit himself to the dealings of society. He had an intelligence confused and superficial, but decidedly human in character. He had some notion of number, knew of a future state, and had a glimmering of moral relations. The circumference of his head was $17\frac{1}{2}$ inches. His brain was not weighed before being immersed in chloride of zinc, but if it is calculated it must have been about 560 grammes. According to Broca microcephaly begins when the brain has a weight of 1049 grammes for males and 907 for females. We have a full description of these two microcephales, and of the anatomy of their brains illustrated with four pages of lithographs, which give their portraits and figures of their skulls and brains. The entire memoir occupies sixty-five pages quarto. It is the most complete treatise on microcephaly in the English language, though behind the study of Giacomini, *I Cervelli dei Microcefali*, in elaboration and comprehensiveness. The authors divide the abnormality into pseudo-microcephaly, in which the diminutive size of the brain is clearly owing to morbid processes, and microcephaly proper, in which no pathological taint can be discovered. A third group comprises those brains in which microcephaly proper constitutes the primary fact, but to this has been superadded at a later period a pathological process. This last is a most convenient group for enthusiastic evolutionists. The authors indicate a number of resemblances between the brains of the two microcephales and different apes, especially particular forms of the sulci and gyri, which it would be too long to reproduce. The method pursued seems to be to compare the two brains with all the bottled brains of different species of monkeys in their possession, and to record every resemblance

noted, however slight. Some of the resemblances are found in the brains of the higher apes ; others are characteristic of those of the lower apes, and in others, as in the relation of the weights of the cerebrum and cerebellum, "the brains of both Fred and Joe approach more nearly to the condition exhibited in the quadruped than to that present in the ape." They point out the similarity of form between the brains of the two microcephales and the brain of a polar bear. On looking at the lithographed figures we see at a glance that the brains of Joe and Freddy belong to a human type, and that the brain of the bear does not. The truth is the learned authors can neither bring all the different brains of microcephales to one morphological type, nor indicate one type of monkey to which microcephales may be traced. Of Freddy's brain the authors observe—"The convolutionary arrangement is more ape-like than human, and it is so consistent in its pattern throughout the whole cerebral surface that we cannot shut our eyes to the possibility that in it we may have a tolerably faithful reproduction of the gyri and sulci which at one time were characteristic of an early stem-form of man." One feels tempted to ask, If Fred possessed the brain of the ancestral ape, why did he not show corresponding simian proclivities, or how did the primeval monkey, who had a *fac simile* of Fred's brain, get on without the Royal Albert Asylum? The authors say in another place, "We have no means, it is true, of being absolutely assured that the cerebral surface of a microcephale ever repeats exactly all the characters of a remote ancestor, but there is reason to believe that in certain cases such an occurrence is not impossible, whilst in the majority of cases some lost convolutionary trait is recovered. If this does not add to the material upon which the theory of descent is built, it at least strengthens the hypothesis and vastly increases the interest of the applications."

The authors thus define atavism : "In a simple arrest of development a transitory embryonic condition becomes stereotyped, as it were, but this does not necessarily imply that the phase which is produced is one which at any previous time in the phylogenetic evolution of the individual was characteristic of the stem-form. Something more is required to constitute an atavism. It is necessary that certain of those ancestral features which are omitted in the ordinary course of development should be reproduced, or that certain of those parts of the phylogenetic history, which in the ontogeny of the individual have become blurred or abbrevi-

viated, should reappear in a distinct and intelligible manner."

The authors indicate as a striking point in two microcephalic brains the marked reduction of that part of the hemisphere which lies behind the fissure of Rolando. In some previous descriptions of such brains this fissure has been mistaken for the præcentral sulcus. The authors find the fissure of Rolando much more firmly marked in man than in the higher apes, and observe that this predominance of the fissure in man is "entirely due to a more exuberant growth of the two convolutions which bound it, and in all probability it has been brought about by the acquisition of the skilled movements of the upper limbs, by the increase in the power of facial expression, and perhaps to some extent by the great increase in the relative length and strength of the lower limbs. The stolid expression, the shuffling gait, and the clumsy action of the hands of an idiot may therefore to some degree be accounted for by the more feeble development of the two central convolutions."

But may not the stolid expression of an idiot be owing to his stupidity, and his awkward gait and action to his incapacity to direct the complex machinery of the human body?

The authors show that the theory of Klebs, who held that microcephaly was owing to an hour-glass contraction of the uterus, cannot hold good of many cases, for the deviation from the normal development of the brain generally takes place at a very early period.

There are many other interesting questions discussed in this treatise, which is made valuable not only by the interesting character of the materials studied, but by the skill, knowledge, and diligence brought to their examination.

PART III.—PSYCHOLOGICAL RETROSPECT.

THERAPEUTIC RETROSPECT.

By Harrington Sainsbury.

Epilepsy, Treatment of, by the Bromo-opiate Method of Flechsig.

In the "Revue de Thérapeutique," November 15th, 1894, mention is made of this method of Flechsig in the review by Dr. A. Sallard of a treatise by C. Salzburg (Leipzig, 1894) on the subject. Attention is drawn to the variable results obtained by prevailing practice in the treatment of epilepsy, these results ranging between 10 per cent. and 70 per cent. of cures. Flechsig's method consists in the administration of opium in the first

instance, commencing with doses of some $\frac{5}{8}$ grain *pro die* of powdered opium or of its extract; this dose is distributed over the day. The quantity of opium is then increased by $\frac{1}{8}$ grain each day till a maximum of four or five grains is taken each day. At the end of six weeks the opium treatment is completely suppressed, and the bromide administration is then begun. This is given in large doses, some 75-105 grains *pro die*, and it is continued for at least two months. The attacks generally yield to the first doses of the bromides.

Several hypotheses are put forward to explain the *modus operandi*, which, we must confess, do not appear to us very convincing. More important is it to note the contra-indications to this treatment which are stated to obtain. These are: The status epilepticus; plethora; the existence of focal cerebral lesions. Further, the treatment is only adapted to institutions or to those circumstances which permit of constant supervision, inasmuch as the primary opium treatment may cause hallucinations or even delirium, and also marked digestive disturbances.

The remarkable results claimed for this method would indicate its employment in all cases of epilepsy rebellious to the usual bromide treatment. It is important to note this qualification, for it is not suggested to make a routine treatment of this method of Flechsigs, but to keep it in reserve.

Epilepsy, Oxide of Zinc Treatment, Method of Herpin.

Dr. J. Corton, Paris, 1894, claims good results for this method. He records seven cases, with four durable cures. The dosage for adults varied between the limits of four and 38 grains, the latter dose gradually attained by a weekly rise of four grains. The dose for children during the first week was some two grains, with a weekly rise of two grains till a maximum dosage of 9-10 grains had been attained.

The only objection to this method was the liability to the production of nausea. Dr. Corton states that he has in several cases substituted the valerianate of zinc for the oxide.

For fuller details the original treatise of Dr. Corton must be consulted; the above are taken from a short notice in the "Revue de Thérapeutique," November 15th, 1894.

Epilepsy, Treatment of, with Silver Nitrate ("Lancet," September 21st, 1895).

In No. 3 of a series of contributions under the heading, "Rough Notes on Remedies," Dr. Wm. Murray, of Newcastle-on-Tyne, records two very interesting cases of epilepsy successfully treated with this drug. One, a confirmed epileptic, who had been fully treated with bromides with but very partial relief as to the fits, and, at "a great sacrifice of memory and general business alertness," was "face to face with the resignation of a valuable appointment." The case was put to him as to the staining of the

skin which a prolonged course of silver nitrate would involve and he elected to run the risk of this. He was put on a nine-months' course of silver nitrate. After the first month the fits ceased completely, and there was no recurrence afterwards. The other case of epilepsy was of thirty years' standing, and, beside the attacks of petit mal, with "occasional large fits," the patient suffered much from neuralgic headaches, muscular twitchings, lassitude, and other minor ailments, to which Dr. Murray thinks the bromides predispose by lowering vitality, and which greatly aggravate the burden of living. This patient also "deliberately accepted a course of silver nitrate, regardless of consequences," with the result that he is "seldom out of sorts, is comparatively free from headaches, has no twitchings, and has never had a trace of epilepsy, not even of petit mal." In both cases slight pigmentation resulted.

These cases may well remind us of an old therapeutic friend and of the common sense characterising the best of treatment, which here exchanges a heavy load for that which many would wisely regard as a mere trifle in comparison: a staining of the skin.

Epilepsy, Biborate of Soda in ("Lancet," October 12th, 1895).

This notice refers to an article by Dr. Féré in the "Revue de Médecine," in which an extensive series of trials with borax is recorded. The outcome is as follows: In the majority of cases the disadvantages of borax outweigh much the advantages; thus of 122 cases treated, in 87 no beneficial result obtained, in 24 the results were doubtful, whilst in 11 undoubted benefit occurred. Besides the small proportion of successful cases, numerous drawbacks in the shape of secondary effects contra-indicate. These drawbacks, classed under the heading Borism, include first alimentary tract disturbances, nausea, vomiting, anorexia—these, in certain cases, may be obviated by giving the borax along with glycerine. Other troubles are dryness of the skin and hair, and redness and inflammation of the mucous membranes; to the latter condition will probably be due the alimentary tract symptoms. Eczema may occur in papular or patchy form, but more commonly it is said to assume a seborrhœic type. General weakness is also present and is explained in part by the malassimilation due to the unhealthy state of the stomach and intestines, in part as a direct toxic effect. More important still was the occurrence in certain cases of albuminuria and general œdema; in one case death occurred with uræmia and hyperpyrexia, and post-mortem the kidneys were found inflamed.

However, in 11 cases undoubted benefit resulted, and these included some remarkable successes, even some which had resisted bromides.

Since the introduction of borax by Dr. Gowers in the treatment of epilepsy, much work on the subject has been done both in this

country and abroad. To this work Dr. Féré's will associate itself as a valuable contribution.

The position, then, which borax will occupy will be as a reserve agent for those cases intractable by bromides, and it will be essential during its administration, especially in large doses, to watch carefully its effects and more particularly to keep an eye upon the urine.

It will be clear from a consideration of the subject which these several references suggest, how large a part in the successful treatment of epilepsy *method* will play. It does so, of course, in all medicine, but it holds pre-eminently in conditions such as the epileptic, where the remedies are legion and the indications so few.

Locomotor Ataxy, Nitrate of Silver in ("Dublin Journal of Medical Science," July, 1895, p. 22).

Loc. cit. Dr. H. C. Tweedy reports a very interesting case in which a patient presenting well-marked symptoms of tabes dorsalis was quite cured by a prolonged treatment with silver nitrate. The patient in 1871 showed the following group of symptoms: Pronounced girdle pains, lightning pains, characteristic gait, requiring the assistance of a stick to steady the balance, sensation of numbness in the feet so that he could scarcely feel the ground, staggering when made to stand erect and close the eyes, also when made to turn quickly. He was put on gr. $\frac{1}{4}$ of nitrate of silver in pill thrice daily. This treatment was continued for a fortnight, then stopped for a week, then resumed for a fortnight. Hospital treatment was suddenly interrupted after six weeks, but the patient continued the use of the drug on the same lines with "tolerable regularity" for two years. In 1873 he was seen and found much better. At intervals the drug was continued till 1876, when he reappeared "with some return of the ataxy." Potassium iodide was then tried, but so unsuccessfully that the silver nitrate was resumed. Lost sight of for six years, till 1882; the patient reappeared this time on account of eczema of the legs. All ataxic symptoms had disappeared, but the patient suffered occasionally from pains in the back and loins, coming on acutely with vomiting; these symptoms, he stated, were each time relieved by a course of silver nitrate. At this time a slaty-blue colour of face and hands was noted, and to a less degree of the rest of the body, but the general health was excellent. In 1894 again seen with scarcely any change except such as was due to age. Off and on he had been taking the silver nitrate for 23 years, and Dr. Tweedy computes the quantity taken, at a very moderate estimate, as 2,000 grains. The discoloration of the skin was not noticed at the end of five years, but was well-marked at the end of eleven.

The writer then considers the question of the total quantity of

silver required to produce argyria and the length of administration necessary, and he concludes :—

1. That no precautions can guard against the staining during prolonged administration.

2. That in this particular case the patient's general health did not suffer.

3. That upon the malady the beneficial effect of the treatment was remarkable, which, speaking in 1894, had disappeared for more than ten years.

4. And, finally, that the discoloration of the skin was not an extravagant price to have paid for the benefits received.

We may, perhaps, take note, for practical purposes, of the smallest quantity of silver salt which, according to Krahmer, has produced argyria, viz., 450 grains. Dr. H. C. Wood (Therapeutics) puts down three months as the longest period of administration permissible without a protracted interruption.

Tabes dorsalis and Serum Therapy.

In the August number of the "Therapeutische Monatshefte," 1895, we find a brief note to the effect that the *serum therapy* of tabes, in spite of many encomiums, does not make way. Subjective experiences of benefit obtained are not denied, but that these depend on suggestion are indicated by the occurrence of similar effects with control injections of distilled water. Actual objective improvement was not observed in any case (Fürbringer and Senator, "Deutsche Med. Wochenschr.," 13 ff.; Wood and Whiting, "Lancet").

Case of Acute Sulphonal Poisoning ("Therap. Monatsh.," January, 1895).

It can hardly be said that we have quite abandoned the search for the philosopher's stone, inasmuch as we are in present hot pursuit of the soporific which shall bring sleep only in its substance, no other gift, certainly no evil one. The like may be said of anæsthetics, and of a long list of therapeutic agencies. Each new drug comes forth flawless—no evil secondary effects attend it. Sulphonal has long been driven from the pedestal upon which it was speedily upreared, and of its occasional poisonous effects we have many instances on record, but these for the most part are slowly brought about. Dr. Karl Hirsch, *loc. cit.*, records a case of acute sulphonal intoxication from a single massive dose. The patient, a young woman, æt. 28-30, swallowed at one dose 25 grammes (380 grains about) of sulphonal in a wine-glass of water. Immediately upon the taking she felt giddy, with fulness in the head, but she retained sufficient self-possession to inflict upon herself a wound of the left wrist. So long as she retained her faculties she did not vomit. She was found unconscious and pulseless. The contents of the stomach had been to some

extent rejected, but this must have occurred after the loss of consciousness. The symptoms calling for special notice were—1st. Somnolence, complete for two days and two nights, it being impossible to rouse the patient, followed by a great drowsiness for four more days; 2nd. The presence of gastro-intestinal disturbances, epigastric pain, with very foul tongue and complete anorexia, but no vomiting, except at the onset and once again on the sixth day. Further, a constipation which resisted all efforts for five days; 3rd. The occurrence of a nephritis (albumen, casts, red and white cells), which first appeared on the fourth day, and lasted three days; 4th. Analgesia, probably present from the commencement, but only observed on the fifth day, when the faculties were sufficiently regained to test this point. The analgesia lasted for two more days; it was specially noted in the legs, and was accompanied by slight anæsthesia (touch).

Of the reflexes, the plantar was slightly lessened at the beginning. No ataxy was observed.

Dr. Hirsch refers to two other cases on record, in which respectively 30 grammes and 100 grammes (Neisser's case) were taken, in each without permanent bad effect. That which we would ourselves accentuate is the *immediate* effect, subjective (giddiness, fulness in the head), which the patient reported, for it is difficult to understand how so insoluble and slowly-acting a drug could produce this, but perhaps in the excited frame of mind which possessed the patient at the time of taking the drug we must discount these subjective sensations, or regard them as reflex disturbances, since in the presence of the vomited stomach-contents there was evidence of a local irritant action. How much of the sulphonal was actually absorbed it is impossible to guess, for not only did the patient vomit up an unknown quantity, but within three or four hours of the taking of the drug the stomach was washed out. Finally it must be noted that hæmatoporphyry, so frequent as a urinary effect in cases of chronic sulphonal poisoning, was not present here.

Trional.

Since the employment of sulphonal, perhaps more particularly since the occasional toxic effects produced by the latter, trional and tetronal, closely allied to sulphonal, have been introduced. Already a considerable amount of experience has been gained with these drugs, but more is needed to establish their precise value. In the "Therap. Monatsh." for May 1895, we find a reference to Dr. Svetlin's trials at his asylum at Vienna (quoted from "Wiener Klin. Wochenschr.," 1895, No. 14). Dr. Svetlin has made use of trional during a period of some two-and-a-half years, and he speaks from an experience of over 3,000 separate doses. His dosage varies from one to three grammes (15 to 45 grains). The administration is at bedtime in a wine-glassful of hot drink, containing one teaspoonful of brandy and one teaspoonful of syrup of

orange. This makes a very pleasant punch, which is readily taken. Sleep sets in from one half to three-quarters of an hour, and lasts from five to eight hours. He records no unpleasant by-effects, and he regards it as a prompt and sure means in simple nervous agrypnia, in the restlessness of neurasthenia, and in melancholy without delirium; also in the lighter forms of maniacal and delusional excitement. He does not find it effective in the nocturnal restlessness of paralytics, or in the severer forms of mental excitement. In some cases of sleeplessness, especially in chronic cases, trional was found useful, in combination with $\frac{1}{7}$ - $\frac{1}{8}$ grain of morphia, or $\frac{1}{3}$ - $\frac{1}{2}$ grain of codeia, and in this combination it proved effective when separately the ingredients were useless. Dr. Svetlin places trional after chloral and opium in strength, but it had the advantage of not showing habituation, though given for two or three months at a time.

Prof. Obersteiner ("Therap. Monatsh.," May, 1895) thus expresses himself as to the value of trional: It is an excellent hypnotic. Fifteen grains is often enough to cause excellent sleep, and Prof. Obersteiner does not exceed the dose of 30 grains. He gives it two advantages over sulphonal—a speedier action and either absence of after effects or the presence of these in much smaller degree. He thinks these differences are to be explained—1st. By the more ready absorption of the drug, trional is less insoluble than sulphonal; 2nd. By a less stability of the molecule, which being hence more easily broken up, is more readily separated from the body. Prof. Obersteiner's results were gained at his private asylum at Oberdöbling, Vienna.

From the County Asylum at Osnabrück, on the other hand, we have the report of a case of chronic poisoning by trional. Dr. Reinicke, under whose care the patient was, makes reference to three cases of chronic poisoning thus far published, viz., those of Schultze, Herting, and Hecker. Of these three, two were fatal. In his own case a point of much importance was that the administration was cautious from the beginning, and the use of the drug interrupted by long intervals. The patient, a well-nourished woman, æt. 26, suffered from acute delusional insanity. The treatment extended from October 15th, 1894, to January 29th, 1895, and, with the exception of two days, the patient kept her bed the whole time. She received 15 grains every second evening. From the 1st of December to the 22nd there was an interval, and again from the 14th to the 22nd of January. The total quantity taken was 600 grains. The last dose given was on January 29th. On the 30th there appeared some feverishness and headache, with gastro-intestinal upset. There was diarrhœa, with some blood in the stools. The urine was also bloody, and contained much albumen, a few red and white cells were found, and some bladder epithelia, hyaline and granular casts, and granular detritus. This condition of urine persisted from the 1st to the 10th of February, though there was gradual improvement. The urine had

been last tested, before the attack, on January 23rd, and was then free from blood and albumen. Considerable cardiac depression co-existed with the alimentary and renal symptoms; the pulse was quiet and small.

The patient ultimately recovered, but she was much weakened and remained very anæmic.—("Therap. Monatsh.," May, 1895, from "Deutsche Med. Wochenschr.," 1895, No. 13.)

Dr. M. Steiner ("Therap. Monatsh.," June, 1895, p. 319) speaks in the highest terms of trional as a hypnotic, notwithstanding the occasionally recorded evils resulting from its use. He agrees with Goldmann that in cases of its prolonged administration if care is taken to meet the constipation and oliguria, which, for the most part, precede dangerous symptoms, and if at the same time carbonic acid water be administered, the dangers may be averted. He orders one to two bottles daily of an artificial seltzer water. Thus prescribed he has never seen harm result.

It is quite clear from the position already reached that trional is an efficient hypnotic, but that it possesses real advantages over sulphonal is not proven. Trional will add itself as another shaft to a very full quiver.

Benzacetin as a Sedative.

Dr. Frank ("Cbl. f. Gynæcologie") recommends this compound in doses of 8 to 15 grains in those cases where hypnotics proper do not seem advisable.—("Therap. Monatsh.," August, 1895).

Chloralose ("Therap. Monatsh.," June, 1895).

This substance is obtained by introducing the chloral grouping into the molecule of glucose, and to describe its composition it has been named *anhydro-gluco-chloral*. It was first described by the chemists in 1889, and first introduced into medicine as a hypnotic in 1893. It is extremely bitter, freely soluble in warm, but very sparingly in cold water (cf. Merck's "Jahrbuch"). Dr. Lad. Haskoves, Assistant Physician in the Psychiatric Clinic at Prag, reports thus of its employment:—Eighty-two patients were treated, 39 women, 43 men. In doses of three to six grains it acted as a nerve sedative; of $7\frac{1}{2}$ to 15 grains as a hypnotic. Sleep sets in in from half to one hour, and it lasts from three to seven hours, this result depending upon the dose, the nature of the disease, and the age of the patient.

The doses to begin with should always be small—3-6 grains. Suitable cases are those of mania, especially in youthful objects, of epilepsy and of alcoholism. Unsuitable cases are those with organic disease of the brain and elderly patients. These are liable to show poisonous effects, convulsions general or partial.

Chloralose does not affect the respiration, the pulse is increased somewhat in force and frequency; the temperature tends to rise about half a degree.

The drug shows some cumulative action, but at the same time

patients are said to grow accustomed to it; this is somewhat contradictory.

The administration is best in solution in warm or hot water, with some strong flavouring added to conceal the bitterness, *e.g.*:

Chloralose, gr. iij-xii.

Cumarin, gr. $\frac{1}{4}$.

Saccharin, gr. iij.

Hot distilled water, ʒiij-ʒiv .

Cumarin is the aromatic principle of the sweet scented woodruff and of the Tonka bean—some other strong aromatic principle might be substituted. Chloralose might be given in cachet or wafer paper. The dose should not exceed 15 grains.

Lactophenin, poisonous symptoms during administration of.

Lactophenin is closely allied to phenacetin; in fact, if the acetic grouping in phenacetin is replaced by the lactic acid grouping lactophenin is the result. From experiments on animals by Schmiedeberg this compound has been found to possess hypnotic, analgesic, and antipyretic powers. These results have been confirmed for man by numerous observers (*cf.* "Merck's Annual Report," 1895). Among these observers Dr. Hermann Strauss now records in the "Therap. Monatsh.," Sept., 1895, p. 469, three cases in which catarrhal jaundice appeared in patients who were taking lactophenin. Up to the present time few by-actions have been reported, and these have been comparatively unimportant, *e.g.*, sweatings and mild degrees of cardiac arrhythmia. Dr. Strauss himself has also noted two cases of rash. His present cases developed well-marked jaundice, with symptoms of dyspepsia, after nine, fourteen, and twenty-one days respectively of lactophenin dosage, $15\frac{1}{2}$ grains four times daily. In each case the drug was given as an antineuralgic, and there was nothing in the cases to throw any light upon the jaundice, except the possible toxic influence of the drug. No other cases of jaundice occurred in the hospital during the nine months which included these cases, and since all three had this one element in common it seems difficult to escape the conclusion that we have here cause and effect.

Dr. Strauss made two experiments upon rabbits with lactophenin, and developed a pronounced gastro-duodenal catarrh but no jaundice. Lewin had previously shown that phenacetin, so closely allied to lactophenin, may produce a like gastro-duodenal catarrh. So far, therefore, as these not very extensive experiments upon animals go, they favour the conclusion that the jaundice in these cases was a toxic drug action.

Dietetic therapeutics we all believe in, and most of us would prefer to take our medicine, if possible, in this form. Iron and phosphorus are favourite remedies for recruiting or building up the depressed powers of the body, and accordingly we shall learn with pleasure that M. Chatin has not only demonstrated that oysters are rich in the halogens, iodine and bromine, but that they

also contain appreciable quantities of phosphorus and of iron. The phosphorus is present as phosphate in organic combination; the iron is present in diatoms, which are in sufficient numbers to impart to the oyster its brown colour. It would seem that the oysters of Portugal are richest in phosphate, each one of them containing a little more than a grain of phosphate.

M. Gautier draws attention to the fact that all aliments of marine origin are rich in phosphorus; cod-liver oil furnishes a good example since it contains glycono-phosphoric acid.

On these grounds we may, perhaps, accord to oysters a special nutritive value. All departments of medicine will rejoice at this, though it will occur to many that the action of phosphorus as phosphate is very far from that of free phosphorus or of phosphorus in its lower forms of combination with oxygen, viz., as phosphite or hypophosphite.

M. Chatin's observations are from the "Gazette des Hôpitaux," May, 1895, No. 61.

Alcoholism is a familiar trouble in special and general medicine, and it may, therefore, not be out of place to refer here to a treatment for the gastritis of drinkers mentioned in the "Gazette des Hôpitaux," March, 1895, No. 38. Prof. Zdekauer orders for this gastritis chlorinated water, according to the following formula:—

Chlorinated water, 8 grammes	} Of this a teaspoonful
Decoction of althea, 165 grammes	
Cane sugar, 8 grammes	
	is given every two
	or three hours.

Under this treatment the craving disappeared completely, the appetite returned, the hypochondriasis departed. In four-tenths of the cases this was the result. For poorer patients Prof. Zdekauer recommends fifteen drops of chlorinated water in some mucilaginous decoction.

In the "Lancet" of October 26th, 1895, we notice a treatment for vomiting by Lasègue by means of tincture of iodine, five to ten drops in sweetened water; this is obviously very much on the same lines as is the above-mentioned treatment of alcoholic gastritis.

GERMAN RETROSPECT.

By William W. Ireland, M.D.

The Methodical Examination of Ear-forms in Lunatics and Criminals.

Finding that there is a difficulty in describing abnormal forms of the ear, Prof. Schwalbe, of Strasbourg ("Archiv. für Psychiatrie," xxvii. Band, 3 Heft), has arranged an exact method by which variations in the external ear may be tabulated. His articles are illustrated by 19 woodcuts of ear forms. Dr. Schwalbe cites a number of papers from German, French, and Italian

sources, which show the extraordinary diligence with which the outward form of this organ has been studied. He remarks that Gredenigo has enumerated 23 categories of ears, and examined 25,000 men and women in Turin, 800 lunatics, and 467 criminals. This observer found very little difference in the form of the ears in these three classes, while Vali found the Darwinian tubercle thrice as common in insane persons and idiots. Schwalbe thinks this difference of result must be due to race, as he finds a difference on this point between the inhabitants of Lower Alsace and those of Lorraine, Upper Alsace, the Palatinate and Baden. Schaffer found that 55 per cent. of Englishmen had the Darwinian tubercle. This shows that when the form of the ear in lunatics and criminals is compared with sane people, they should all belong to the same race. Schwalbe does not state any conclusion, but observes at the end of his paper that many so-called abnormalities in the ear, which are treated as proofs of degeneration, fall within the bounds of normal variations, and many of them are marks of imperfect development of the organ or have analogies with the animals nearest in structure to man.

The Centres for the Muscles of the Neck and Trunk.

Dr. H. Werner, of Jena, with the support of Prof. Ziehen, has made some experiments in order to resolve the questions: Where lie the cortical centres for the neck and trunk in the dog? and is there a centre for the movements of the eyes in the frontal lobe of the same animal? In his paper ("Allgemeine Zeitschrift für Psychiatrie," lii. Band, 1 Heft), Dr. Werner explains the successive steps by which, after the first discoveries of Hitzig and Fritsch, the localisation of the cerebral functions was worked out. His own experiments are given at length. He finds that the dog possesses two centres for the muscles of the neck, one in the frontal lobe in front of the pre-Sylvian fissure, the other in the parietal lobe at the lateral end of the gyrus sigmoides posterior, below the centre for the fore paw. Electrical stimulation of both centres causes a drawing of the snout towards the side stimulated. Dr. Werner explains Hitzig's finding that the frontal lobe was not excitable to electricity by saying that he used too weak currents. He over-rules an experiment of Ferrier by saying that he used too strong currents. Hitzig, de Boyer, and Kusick found that after extirpation of the frontal lobe there were no derangements of muscular motion, but this Werner attributes to the parietal centre taking up the function of its frontal colleague.

The centre for the muscles of the trunk lies upon the gyrus sigmoides posterior, between the centre of the two extremities. This centre acts upon the muscles of the same side. Here he agrees with the results obtained by Unverricht and Kusick and differs from Munk, who places the sphere for the muscles of the trunk in the frontal lobe of the dog.

He finds that there is no centre for vision in the frontal lobe of the dog. Here he disagrees with Ferrier, who found in the frontal lobe a centre for the movements of the eyes.

The situation of the centres generally varies in different individual animals within definite limits.

The excitability of the cortex increases to a certain degree through the action of the electrical stream.

Degeneration of the Corpus Callosum.

Prof. G. Anton observes ("Jahrbücher für Psychiatrie und Neurologie," xiv. Band, 1 and 2 Heft) that it is agreed that the functions of the two hemispheres are not exactly co-equal. In general they work together, but in a lesser degree each has an independent function. A case which he had observed throws some light on the question whether the fibres of the corpus callosum form a commissure or an association system, or simply a connecting structure.

Dr. Anton's patient was a bookkeeper, sixty-five years old, who was suddenly seized with symptoms of left homonymous hemianopsia. On the left side of the body there was a diminution of muscular power and of the muscular sense, with a notable diminution of the cutaneous sensibility. This attack was accompanied by giddiness, and followed several weeks after by delirium and hallucinations. Dr. Anton saw the patient two years after. There was considerable diminution of power on the left side, which had fallen into disuse in spontaneous and combined motions. The muscular sense on the left side was much injured; the speech was not affected.

On examination after death the posterior cerebral artery was found blocked up; there was softening of the cuneus and a part of the calcar avis, and the posterior two-thirds of the optic thalamus, and the corpus geniculatum internum and externum were softened and the place occupied by a cavity. In the forceps of the corpus callosum, on its under and posterior part, there was a softened spot as large as a pea. On the right side the optic tract showed marks of secondary degeneration, but the tapetum and fasciculus longitudinalis were intact. On the left side the optic tract was unaffected, but there was secondary degeneration of the tapetum. Dr. Anton holds that the tapetum must not be a transverse commissure, otherwise the degeneration would have affected both sides. What was found might be explained by the assumption that the fibres of the tapetum serve to connect the two hemispheres with one another at points which are not analogous.

Antiquity of Hypnotism.

Brugsch Pasha, the celebrated Egyptologist, has shown ("Zeitschrift für Hypnotismus," April, 1894), from a papyrus written in the first century, that the ancient Egyptians used

hypnotism as early as two thousand years ago. They used passes to induce the hypnotic state, and sought to practice on innocent boys to render them clairvoyants.

Periodical Changes in Brain Power.

Under this title Dr. Richard Stern has described two cases which he met with in the hospital at Breslau ("Archiv. für Psychiatrie," xxvii. Band, 3 Heft). Both these patients had received injuries to the head on one side, and, amongst other symptoms, Dr. Stern noted a diminution of the sensibility of the skin and of all the special senses, paresis with ataxia of the voluntary muscles, and a diminution of intellectual power. The loss of all these functions came on at the same time and generally lasted from one to three seconds; in one case the intermission lasted 23 seconds, and in another, for acoustic impressions, from 15 to 23 seconds. There were intervals of normal function, which generally lasted longer than the declensions of sensibility, motor strength, and intellectual energy. The intermissions in these patients were studied in a painstaking manner with the aid of apparatus for neurological and psychological observation. The details are recorded at length in a paper which fills sixty-eight pages, illustrated by plates and diagrams.

Dr. Stern observes that the diminution of mental power and loss of memory was accompanied by motor aphasia and a visible falling off in distinct writing. He notices that David Hume, in his "Treatise on Human Nature," mentions that if we look at a small black point on white paper at some distance, it is only visible at intervals. More lately, Urbantschitsch has observed such rises and falls in the perception of weak impressions of smell, taste, and temperature, and this has been confirmed by the exact observations of Eckener and Pace. Dr. Stern regards the Cheyne-Stokes phenomenon as a special form of this intermission of functional nerve power. He thinks that in the cases which he has described, and in another which has come to his notice since writing his paper, we have a pathological exaggeration of a physiological process. He considers that the intermittent diminutions of the power of speech, of memory, and the other manifestations of mental activity show that we have to do with an affection of the cerebrum. Whether any other part of the nervous system be affected at the same time is doubtful. The reflexes of the iris and tendons were not altered.

Affection of Speech.

Dr. Friedmann gave to the meeting of neurologists at Baden-Baden in May last ("Neurologisches Centralblatt," Nr. 13, 1895) an account of a young man who had an uncommon difficulty in the utterance of words. He had learned to speak about the usual time, but through bashfulness in the school the power of articula-

tion was much impaired. He was now 18 years of age, and sound of body. As a rule it takes two or three minutes before he can make words come forth; when they do begin he speaks without any difficulty, and quite fluently. During the latent period he gives the impression of a dumb person. He has none of the customary motions of the stutterer. He can at once write down what he cannot speak. He can multiply double figures by mental arithmetic with unusual quickness. Dr. Friedmann thinks that the obstacle is in the cortex between the area of the conception of words and the path of the innervation of speech. He does not think there is any hysterical affection of the will.

Amusia.

Dr. Edgren ("Deutsche Zeitschrift für Nervenheilkunde," 6 Band, 1 Heft, quoted in the "Centralblatt für Nervenheilkunde," June, 1895, and "Neurologisches Centralblatt," Nr. 15) has reviewed fifty-one cases of musical aphasia taken from various authors. He uses the word *amusia* as the counterpart of *aphasia*. Note-blindness and tone-deafness are used as corresponding deficiencies to word-blindness and word-deafness. He has also vocal motor *amusia*, the incapacity to sing, and instrumental motor *amusia*, the incapacity to play on an instrument, and also musical *agraphia*, inability to copy music. He divides the cases which he has studied into three groups—*aphasia* without *amusia*, *aphasia* complicated with *amusia*, and *amusia* without *aphasia*. Dr. Edgren was able to study one case in particular. A man 30 years of age, in good health, but given to drink, received an injury to the head, after which he complained of headache, confusion, sickness, difficulty of seeing, and incapacity to work. Illusions of taste and tone-deafness came later. Before the accident he had been an intelligent man, with a decided talent for music, which had entirely left him. He heard noises, but could not distinguish melody. This was accompanied by word-deafness, which disappeared in a month. The power of singing was injured to a marked degree, for owing to the tone-deafness the control of the musical voice was lost. These symptoms continued for three years, after which he died. On examination a recent *pachymeningitis hæmorrhagica* was found in the seat of an old softened area occupying a space about three centimetres broad and almost five centimetres long in the anterior part of the left Sylvian fossa. There was a similar softening in the posterior part of the right Sylvian fossa. A later examination of the brain showed a destruction of the two anterior thirds of the first right temporal gyrus, and of the anterior half of the middle temporal gyrus, and further the destruction of the upper and outer surface of the posterior half of the upper right temporal gyrus and of the under edge of the second temporal gyrus. Dr. Edgren thinks that the defect in the anterior half of the first and second temporal convolutions is

probably the cause of the enduring tone-deafness. It is to be noted that the lesions existed both in the right and in the left hemispheres and in analogous areas. Edgren gives the following conclusions:—

1. The musical capacity may be destroyed partially or entirely just as the capacity for language may be so affected by lesions in the brain, and where the destruction is partial the musical faculty may be resolved into its component from which different forms of amusia may arise.

2. These forms have a certain clinical independence, both in their relation to one another and in their relations to aphasia.

3. The clinical forms of amusia are often accompanied by analogous forms of aphasia.

4. Amusia can exist without aphasia, and aphasia without amusia.

5. It is probable that the various clinical forms of amusia, or at least some of them, have anatomical substrata. They may be localised in places near the areas of aphasia, but not in the same places.

6. It is highly probable that tone-deafness may be localised in the first or in the first and second gyrus of the left temporal lobe in front of the place where an injury causes word-deafness.

Amnesia after Recovery from Suspension.

Dr. Luhrmann mentions in his paper ("Zeitschrift für Psychiatrie," lii. Band, 1 Heft) 26 cases of persons who have been rescued from hanging. He himself records three male patients who were brought to the City Asylum of Dresden after unsuccessful attempts at suicide. Two of these were drunkards, one a melancholiac. After being cut down the patients were for some time insensible. This was succeeded by convulsions. It was found in each case that the would-be suicide had entirely forgotten his attempt. This oblivion went back for an hour or two previous. Dr. Luhrmann considers the question whether these were real epileptic fits following the closure of the carotids and the asphyxia, or whether the fits were hysterical and due to the mental effect (seelisch ermittelt). He seems to accept the latter explanation. This amnesia covering the occasion of the hanging might affect the evidence in a medico-legal inquiry.

Artificial Hallucinations in Alcoholic Delirium.

Dr. H. Liepmann has made in the Charité Hospital of Berlin some studies on the delirium of drunkards ("Arch. für Psychiatrie," xxvii. Band, 1 Heft). In examining 52 patients he found that in 40 of them he could induce visions by pressing upon the eyeball, whether closed or open. These spectra were of several kinds, appearances such as the sun, moon, stars, or lightning, appearances of print or writing in large characters, and figures of

men, buildings, and utensils. In these experiments visions of animals were not common; rats and mice were not seen. In spontaneous visions there were 70 per cent. who had illusions of animals, and 40 per cent. who had hallucinations of hearing. Dr. Liepmann accounts for this disparity by saying that in spontaneous hallucinations the patient is more deeply affected with terror or disgust by visions of animals, and this causes him to keep them in remembrance more strongly and talk more about them.

More Experiments.

Dr. Alzheimer has repeated Liepmann's experiments in the City Hospital of Frankfurt ("Centralblatt für Nervenheilkunde," October, 1895). He observes that not only does pressure upon the eyes cause visions in the delirium of drunkards, but that a similar result is produced in epileptic and hysterical insanity, in general paralysis, and other forms of mental derangement. In fact, when the eyeballs in healthy people are pressed there appear streaks of light, colours of different patterns, and other spectra which a little imagination might translate into visions of stars, balls of fire, spots upon handkerchiefs, rings, spiders, and other figures. In insanity not only the imagination wanders beyond the control of the judgment or will, but the whole nervous system is often in an excited condition. In one of Dr. Alzheimer's cases the patient was blind through opacity of both corneæ. Several years later he became insane, after which he had visions of flowers and animals, men, candles, and gardens. There were also hallucinations of hearing, reproaches, and threats. On pressure being applied to the eyeballs the doctor asked, "What do you see?" The patient answered, "Stars, flowers, a number of men, women with children, nothing more; snakes, other beasts." "How do they look?" "Like mice; everything is quite grey." "What were the flowers like?" "Also grey." Some weeks after the man died. Both optic nerves were found to be atrophied, the nerve-fibres being reduced in number by about one-third.

The following case is reproduced:—W. Sch., machinist, 27 years old, has suffered for six years from frequent epileptic attacks; is deeply demented. For four years has had hallucinations of hearing, sight, and general sensation before and after the epileptic attacks; is very excitable. He complained of being much plagued by the other patients; would not be quieted; went behind the doctor. It seemed as if a fit was coming on. When pressure was applied to the eyeballs he was asked, "What do you see?" "Nothing; a sun, stars, a house; it is on fire. There is a fellow like a devil, a shower of fire, a cloth with streaks of blood." Maintains that he has really seen these things. "The doctor has put them into his eyes." Half-an-hour after an epileptic attack came on. The day after he could still talk about the visions he had seen.

In one maniacal patient, who was thought never to have had hallucinations before, on pressure being applied to the eyes he saw stars and suns, mosaics, a black wolf, a forest with animals dancing about. He said "Now leave me alone; I am crazy. Is this real, or is it hypnotism?"

Curative Effects of Febrile Disturbances in Insanity (quoted in "Neurologisches Centralblatt," Nr. 13, 1895).

Setting out from the fact that some cases of insanity have shown improvement during acute febrile disturbance, and some have even recovered, Dr. Wagner has tried for several years to treat some of his patients by the injection of tuberculin. In several cases there were favourable results, and in two a rapid recovery. These experiments were given up for a while owing to some reasons not explained, but were again resumed in company with Dr. Boeck. The object aimed at was to excite in the patient a febrile action of a moderate character, the temperature not to exceed 39°. At first only one milligramme of tuberculin was injected, and the dose gradually raised. In three cases thus treated a recovery ensued, and some patients so far improved that a complete restoration to sanity might be expected. After every injection some improvement was noticed, which was sustained by each new administration of the tuberculin. The three cases which recovered gave little hope of spontaneous improvement as the insanity had lasted over two years. The bodily weight increased along with the improvement in the medical symptoms.

Dr. Wagner suggests a trial of other bacteria of protein as likely to excite a variety of actions, some of which might be beneficial. Dr. Boeck records the further prosecution of these experiments begun in Graz and continued in Vienna ("Jahrbuch für Psychiatrie," xiv. Band, 1 and 2 Heft, 1895). He tried them in 41 cases, of whom 11 men and 22 women were treated with tuberculin; 10 of the female patients recovered; some of the male patients improved, but none recovered; eight were treated with cultures of pyocyaneus, but this was soon found to be attended with inconvenience. Those cases which recovered under the production of febrile excitement were affected with confusional mania, which gives the most favourable prognosis. Cases of secondary dementia and of paranoia scarcely showed any improvement, though there might be some when the paranoia was passing into confusional insanity. Dr. Boeck treated one case of general paralysis without any improvement; but he thinks this disease is not unsuited for such experiments, especially in its early stages. He thinks that recent cases are better fitted for treatment with tuberculin than chronic ones, and he prefers to deal with young persons from 25 to 30 years of age. It is not clear what factors are operative in this improvement, whether increased change of tissue or increased activity of the lymphatics. The improvement was found not to

keep pace with the height of the fever. A review of the report of the cases described shows that the improvement in the mental symptoms was accompanied by a rapid increase in bodily weight.

Extirpation of a Tumour in the Brain.

Dr. O. Kappeler describes ("Deutsche Zeitschrift für Chirurgie," Band xl., p. 500, quoted in the "Centralblatt für Chirurgie," 21st September, 1895) a case of a smith, 43 years of age, who had paresis of the right arm gradually progressing. It was followed by headaches, first slight, then frequent and lasting, and by fits of Jacksonian epilepsy, also twitchings in the right arm and leg and facial nerve, which seldom extended to the whole body. The fits became more violent and more frequent, and finally, after about a month's illness, were accompanied by dulness of sensation and mental apathy. Dr. Kappeler diagnosed a tumour of the cortex at the left motor area for arm and leg. He determined to open the cranium on the spot. Following the method of Schenk-Kocher the point G was fixed, at the place where the first and second frontal meet the anterior median gyrus, cutting round this point. The dura mater was ribbed and white, 3 mm. thick, with several enlarged veins. Immediately on cutting the membrane a soft bluish grey tumour came into sight. It could be examined with the finger, and was nearly as large as a duck's egg. It lay in the upper part of the fissure of Rolando, and had pressed both cortical convolutions asunder, flattened them at the sides, and deepened the sulcus. It was raised up with the help of the knife handle insinuated into the sulcus. There was only moderate bleeding in the place left by the tumour, which was stopped by plugging with sterilised gauze. Good progress, collapse after the operation soon passed away; the pulse at first very rapid; soon sank to normal after removal of the gauze tampon. After leaving the hospital the patient had no more fits nor headaches, improvement physically and mentally decided, lessening of the paresis in arm and leg so that he could work a little. The extirpated tumour was pronounced by Dr. Hanan after microscopic examination to be an epithelioma springing from the dura. The prognosis against return was thought to be favourable.

A Nail Embedded in the Brain.

Dr. Hebold at the meeting of the Psychiatric Association of Berlin ("Neurologisches Centralblatt," Nr. 13, 1895) brought forward the case of a shoemaker with hereditary tendencies. Ten years before he had suffered from headache, and had been in an asylum. He was again admitted suffering from delusions of persecution, to which soon were added delusions of grandeur. He was at first highly excited, but calmed down, and in a short time improved so much that he was discharged. Not long after he was

brought back to the asylum for attempting to commit suicide by driving nails into his hand. He appeared much distressed, and complained of weakness in the eyes. A right hemianopsia was found; the temperature was high, and after being insensible for a short time, he died. On examination a nail ten-and-a-half centimetres long was found embedded in the left occipital lobe of the brain, which had caused suppuration and softening.

Dr. Jacobssohn, who reports the case, observes that it is remarkable that such a lesion did not cause more distress. He does not say how long the nail had remained embedded in the brain.

Anæsthesia with Loss of Motor Power and Somnolence.

Dr. Heinrich Witte, in an inaugural dissertation, Leipzig, 1894 (reported in "Zeitschrift für Psychologie," Band ix., Heft 2, and in "Centralblatt für Nervenheilkunde," August-September, 1895), gives a *résumé* of the descriptions of several physicians, of patients affected by total anæsthesia who can be thrown into a somnolent condition by closing the remaining senses to outward impressions. There is an account of some of these curious cases in our German Retrospect for January, 1893, p. 129.

Dr. Witte adds another case observed by himself, a woman named Ida G., who had been under medical observation for six years. There was a hereditary neurosis in her family; the exciting cause of her illness was a fright which she received when gathering wood in a forest. This brought on a fainting fit with hysterical convulsions. She was then sixteen years old. This was followed by other attacks of a hysterical character. Towards the end of her first pregnancy, owing to her erratic conduct, she came into the hands of the police, and on the 10th of April, 1888, Ida G. was admitted into the Psychiatric Clinique at Leipzig. On admission a slight exophthalmus was noticed. She soon fell into a state of stupor which passed away, and then returned again and again. During the intervals her intelligence was clear, but hallucinations of hearing and sight gradually came on. On awaking from the stupid state there was a loss of memory to some occurrences. On the 1st July she was freed from her pregnancy by perforation of the membranes. Ten days after she again fell into stupor. Upon this intermittent condition there suddenly supervened anæsthesia of the cutaneous surface of the head, which was followed by total anæsthesia of the whole body, with intervals of deficiency in the sight and hearing. At some times the loss of vision amounted to complete amaurosis. In the summer of 1890 she was in a state of complete anæsthesia of the surface, and the eyesight was narrowed to a small central field, so that two metres off she could scarcely discern a face. The hearing was diminished, and the sense of smell and taste appeared to be lost. Delusions of an erotic character appeared, generally lasting about five days to be succeeded by somnolence. She believed herself to be a queen, immensely rich; with the left

eye she could see her bridegroom, a soldier and prince, who was to deliver her from the asylum. Those delusions were sometimes accompanied by outbursts of rage which rendered seclusion needful; recovery came suddenly. On the 3rd of June, 1893, she had awakened from a prolonged sleep, the delusions were found to have disappeared, sensibility was restored, and the use of the senses was found to be normal. She was sent home to her parents after having been about four years in the clinique. After two months she was brought back pregnant for the second time. At the end of her full time she was delivered of a daughter, a small child, but save for a mark on the left forehead about the size of a thaler, presenting nothing abnormal. The anæsthesia and sensory deficiencies and delusions returned, though scarcely to the same extent. They again disappeared after a period of somnolence. During the total anæsthesia Ida had no sense of the position of her limbs, and did not remark when they were moved about if the change did not meet her sight. When her head was pushed she recognised this by sight, not by feeling. She generally remained out of bed the whole day. As on account of her narrowed field of vision Ida could not see her own legs, she kept her eyes fixed on the ground about two yards in front. She could stretch herself, and had the control of the movements of the fingers as long as she looked at them.

When the eye-lids were held down for thirty seconds, even when hearing was not cut off by the stopping of the ear-passages, Ida sank into a condition of apparent unconsciousness, the limbs were stretched and the whole muscular system became rigid. The eyes were turned inwards and upwards. This somnolent condition generally lasted for several hours, and sometimes after awaking she remained in a confused state of mind. Witte regards Ida as a case of hypnosis. In the similar case described by Strümpell, the condition was considered to be one of physiological sleep; but Ballet, who met with some of these curious patients, regards the somnolent condition as an autohypnosis.

As the result of his studies Witte gives the following conclusions:—(1) In total anæsthesia the unaided sense of sight is able to maintain the body in an upright position as long as the eye has a fixed object to rest upon. (2) Motility, that is to say the capacity of innervating all the muscles, is not met with in pure anæsthesia. (3) The well-known manipulations used to induce the hypnotic state have a purely suggestive influence; but stimuli pass by the sensory nerves to the brain which act upon certain parts of the brain independently of consciousness.

The Castration Question.

How well Medicinal-Rath Dr. Kroemer, Superintendent of the Provincial Asylum at Neustadt, is qualified to write the history of the twenty years' controversy on ovariectomy may be inferred

from the fulness of his reading. Above two hundred papers are quoted, mostly in German, French, and English, and his article fills seventy-four pages of the "*Zeitschrift für Psychiatrie*" (lii. Band, 1 Heft). He has collected above two hundred pages about operations on the uterine appendages undertaken on account of neuropathic affections. Two hundred of these operations were followed by benefit to the patients, and in one hundred the result was either doubtful, indifferent, or unfavourable.

The Medicinal-Rath gives us a report of five cases of women afflicted with hystero-epilepsy admitted into the asylum at Neustadt who derived benefit from ovariectomy. He sums up that amelioration of the mental disorder came to all in the end with improvement in the bodily health. Nevertheless, in reading over the detailed reports we see that recovery did not speedily follow the operations. The best case was discharged one year and two months after the ovariectomy; another remained two years and four months; a third nearly four years; while two of his patients are still in the asylum not yet sane, three and six years after being operated upon.

Dr. Kroemer thinks that there are many cases of women who have become insane through irritation of the ovaries who might derive benefit from surgery. He considers the argument that the operation entails sterility on the women is of no weight, as such women are likely to bear unhealthy children and thus propagate their neuroses. Dr. Kroemer would not confine these surgical benefits to the female sex. As he observes, there are young men who, hitherto quite healthy, on the arrival of pubescence, become epileptic, take to reckless masturbation, or become maniacal and finally demented. Castration would stop the reflex irritation acting upon the brain, and thus cut short the progress of the insanity. The operation is not dangerous, and is followed by speedy improvement in the bodily condition.

Every stock-breeder knows this, and makes good use of his knowledge. Why, asks the learned Medicinal-Rath, should it be so different with men? He informs us that Semiramis was so strongly impressed with the force of such considerations that she caused weakly and poor-looking men to be castrated lest they should inconsiderately diminish the vigour of the Assyrian breed. While Dr. Kroemer approves of this radical measure, which he thinks might be adopted against the poor health and disease of our own day, he is careful to explain that he is far from advising that every young man who becomes maniacal or falls insane at the period of evolution should be castrated. He is of opinion that, as in the case of the women, full consideration should be given to each patient as to the propriety of an operation. The loss of manhood in some unsound and neuropathic individuals is not to be deplored. If Burkhardt, he argues, could venture to treat his maniacal patients by the removal of a portion of the motor zone of

the cortex, why should we boggle over a much less serious operation, which would free the patient from a peripheral cause of mischief and disturbance, leaving him to the enjoyment of a healthy brain, better bodily nutrition, and a feeling of general well-being?

The Fibres of the Corpus Callosum.

Dr. Oscar Vogt has two papers in the "Neurologisches Centralblatt," Nr. 5 and 6, 1895, on the fibres in the middle and caudal portion of this commissure. He has made his studies on normal brains. The old view was that the corpus callosum connected analogous parts of the two hemispheres. But studies made on this structure in the lower placentalia went to show that it also connected heterologous parts, and this was confirmed by the observations of Sherrington and Muratoff on the course of degenerated fibres. A tract of fibres stretching into the lateral walls of the posterior and middle cornua of the lateral ventricle, to which the name tapetum was given, was regarded as a part of the corpus callosum. Forel and Onufrowicz* found this structure entire in a brain in which the corpus callosum was absent. They held it to be the caudal end of the association-fibres which connect the frontal and occipital lobes of the same hemisphere. This was confirmed by the observations of Kaufmann and Hochhaus. The former found the tapetum entire where the corpus callosum was softened. Muratoff studied this question in the dog. He traced the fibres from before backwards to the tapetum, connecting different parts of the same hemisphere. He called this system of fibres the fasciculus subcallosus. Beever and Sachs still hold that the tapetum is a part of the corpus callosum. Vogt tells us that his own studies have shown him that the tapetum contains both fibres of the fasciculus subcallosus and of the corpus callosum. The tapetum is made up of an inner layer of bright coloured fine fibres, and of an outer layer of fibres coarser and of a darker colour, which is much broader behind. The fine fibres belong to the fasciculus subcallosus, the coarser ones to the commissure.

Vogt has found that a part of the fibres of the inner layer mix with those of the outer layer. He has succeeded in tracing the fibres of the fasciculus subcallosus to the nucleus caudatus. He combats the views of Sachs that the connection of the different parts of the brain are kept up solely through the middle brain.

Dr. Vogt's researches are of the most painstaking character; he enters into details which it is impossible to condense. He has made a careful study of the distribution of the fibres in the corpus callosum of the mouse. His observations are illustrated by some schematic woodcuts. He seeks the first traces of connecting fibres in the reptilia and follows them out in the lower mammalia. In general his results agree with those of Beever. In his second

* See German Retrospect, "Journal of Mental Science," Jan., 1889, p. 604.

paper Vogt remarks that all comparative psychology, as well as the newest results of anatomy, show that the sense of smell is phylogenetically the oldest, and in the lower vertebrata the most important of the senses. He finds that the fibres of the fornix longus and the fibres of the cingulum going to the gyrus subcallosus, as well as the middle band of Lancisi, belong to the olfactory tract.

PHYSIOLOGICAL PSYCHOLOGY.

By Havelock Ellis.

The Psychology of Pain.

The neurologist and alienist are constantly concerned with pain, yet the psychology of pain still remains very obscure. What precise pathological or physiological process do we think of when we admit the presence of pain? What is pain?

This is a question which has lately been discussed, with a certain amount of agreement, by Prof. Strong, of Chicago, Dr. Nichols, of Harvard, and Mr. G. W. A. Luckey (Strong, "Psychology of Pain;" Nichols, "Pain Nerves," "Psych. Review," July and September, 1895; Luckey, "Some Recent Studies of Pain," "American Journal of Psychology," October, 1895; Marshall, "Psych. Review," Nov. 1895).

The theories of pain may be divided into three groups: (1) Those which represent pain as a quality of sensation generally; (2) those which class pain as a distinct sensation with special nerves; (3) those which class pain as a certain degree of sensation, but not as an element of all sensation.

The first—including the *quale* theory, or aspect theory, as Strong calls it—is a very ancient one, and was substantially held by Aristotle; in more recent times by Wundt, Höffding, Külpe, Lehmann, Sully, Bradley, and especially Marshall, who has given the best exposition of it. It regards pain, as well as pleasure, merely as colouring, "feeling-tone," a manner of experiencing sensations and ideas. It is a great mistake, Marshall holds, to place in the class "sensation," a mental state which lacks one of the most marked characteristics of sensation in general, *i.e.*, special terminal organs. According to this view, pain can never be an isolated experience, but may belong to any element of consciousness; both pleasure and pain are "primitive qualities of psychic states," the first coming when the energy involved in reaction to a stimulus is greater than usual, the second when it is less. The pain sense of the skin is thus not really a pain sense, but an exaggeration of a sense whose normal product is, what Marshall calls, the cutting-pricking sensation. It is a seductive theory, but, as both Strong and Luckey point out, it cannot be

carried into every field of sensation and it by no means explains all the pathological facts.

According to the second group of views, pain is felt because we possess specific pain nerves. The delicate investigations of Prof. von Frey, of Leipzig—showing by the application of fine hair points to the skin the separate existence of pain points and touch points—support this view, though Nagel, who has repeated these experiments, explains them differently. Dr. Herbert Nichols is a vigorous advocate of the existence of pain nerves, and regards the *quale* theory as a traditional metaphysical monstrosity. He considers pain nerves as developed for the purpose of responding to excessive stimulation; as a warning against violent and injurious influences, while the nerves of other senses (sight, sound, heat, etc.) cease acting when the stimulus becomes so intense as to be injurious. He argues that touch, heat, and cold fibres are each bound up with their own separate pain fibres—granting that these exist—and that the heat and the pain fibres have similar or identical end organs. It is a simple theory, with little against it, Nichols remarks. It seems, however, rather extraordinary on this theory, that remote pain nerves which have never had any exercise can suddenly come into such remarkably energetic action.

The theories of the third group—as expounded in Mr. Luckey's very useful paper—regard pain as an intense degree of certain classes of sensation. Thus Oppenheimer, of Heidelberg, who has made an extremely interesting investigation of the matter, considers that “the real cause of pain is a disturbance of tissue, in particular a chemical disturbance, whereby either there is excess of the normal products of destruction, or products arise through the influence of a foreign body,” there being only one apparent exception, the induction current. According to this physiological theory of pain, the connection between the peripheral tissue and the nervous centres is through the vaso-constrictors, and numerous pathological and anatomical facts are brought forward in support of this view. For a full exposition of this theory the reader must be referred to Luckey or to Oppenheimer's own work, “Schmerz und Temperaturempfindung.” It explains many phenomena admirably and deserves careful study.

Goldscheider's theory, to which Luckey inclines, belongs to the same group. He maintains that “the sensation of pain is peculiar to the pressure nerves and the nerves of common feeling, but fails in all other sense nerves. Sensations of other sense nerves may be unpleasant, but not really painful.” Pain is thus rather an intensive degree of a sensation than a quality of it, and the pains of inflammation are due rather to increasing pressure than to chemical changes. As to the origin of pain in general, Goldscheider believes it to be due to a process of summation in the grey substance of the cord, and (with H. Head) that the real source of pain is in the spinal ganglion cells. This theory easily

explains many pathological facts, for any lesion or lowering of the excitability of the cord would produce analgesia or anæsthesia. Although it is not yet possible to speak definitely, the theory of Goldscheider, as expounded in his latest work, "Ueber den Schmerz," is at least as promising as any.

Those who, like Nichols, argue in favour of pain nerves, are not so clear regarding the existence of pleasure nerves. Luckey emphasises the distinction between pain and discomfort, and argues that the real opposite of pleasure is not pain, but discomfort. This suggestion seems worth bearing in mind.

Reaction Time.

Mr. Bache (R. Meade Bache, "Psych. Review," September, 1895) thinks there is an impression abroad that a quick reaction time accompanies high intellectual development. Perhaps he is right, but there is no reason why such an impression should exist, for there is much evidence of various kinds tending to show that motor mental processes are slower in persons of high intellectual development. Mr. Bache has, however, done well to investigate the matter systematically. He has long since observed what seemed to be the greater automatic excellence of individuals of lower race as compared with those of higher race, and has now submitted the matter to experimental tests, with the aid of Prof. Lightner Witmer, of Pennsylvania University. Whites, Indians, and Africans, about twelve of each, mostly between the ages of 15 and 25, were tested as to their reactions to auditory, visual, and electric stimuli (presumably they were all males). The tables here given show that the Whites are relatively slow as compared with the Indians and Africans (one of the Whites was to all three tests about three times slower than one of the full-blooded Indians). But, contrary to Mr. Bache's expectations, the Indians are quicker than the Africans. He thinks this may be explained by (1) the effects of slavery, (2) a considerable admixture of white blood in the Africans examined, and (3) the special quickness required in Indian life.

Prof. Baldwin has recently reprinted from the "Psychological Review" a collection of studies from the Princetown Laboratory. One of these is of special interest in the present connection ("Types of Reaction"). In this he argues that Wundt and some other psychologists are not justified in concluding that there is only one normal type of reaction and that variations from this must be regarded as abnormal. He finds at least two kinds of motor reaction: (1) One, which he calls *kinæsthetic motor*, in which reaction is quicker when the eye is fixed on the hand which is to react; (2) *visual motor*, in which the reaction is quicker when the eyes are blind-folded and attention is concentrated on the thought. He seeks to explain this by reference to the well-known sensory and motor forms of aphasia, and the corresponding visual,

auditory, and motor speech types. A man's reaction-time will show the influence of his memory type. The hand has, next to the tongue, the most complex movements to perform, and in hand movements the influence of the sensory or motor type is likely to persist. The general result, he concludes, is that "distinctions supposed to be established once for all by various researches must be considered as largely individual results, inasmuch as the authors have not reported on the type of the reagent. But, for that very reason, these results may have great value, as themselves indicating in each case this very thing, the type of one single reagent and in so far some of the general characteristics of that type. What we now desiderate in a great many departments, as, for example, in the treatment of school children, and in the diagnosis of complex mental troubles, is just some method of discovering the type of the individual in hand. If reactions vary in certain ways, according to the types which they illustrate, then in reaction experimentation we have a great objective method of study. But before the method can be called in any way complete, there should be a detailed reinvestigation of the whole question, with a view to the great distinctions of mental type already made out by pathologists."

In "Mind" (Oct., 1895), Dr. Titchener criticises Baldwin's view from the standpoint of the Leipzig school, and while admitting that the type theory is probably correct, does not consider the evidence as yet conclusive. Baldwin defends his views in a later paper ("Mind," Jan., 1896).

The Experimental Induction of Hallucinations.

It is generally admitted that processes similar to those that are normally accompanied by consciousness do sometimes take place without being accompanied by consciousness. These "parasitic states" may sometimes come to form a kind of sub-conscious dream, and in extreme cases become so highly organised as to form a true "secondary personality." With these phenomena, which have been specially studied by Janet and Binet, may be associated the phenomena of the so-called "subliminal self," *i.e.*, automatic writing, the induced phenomena of crystal-gazing, etc.

Prof. Newbold ("Experimental Induction of Automatic Processes," "Psych. Review," July, 1895) has recently been carrying on various experiments and observations which have led him, while not questioning the results obtained by so skilled and experienced an investigator as Janet, to throw doubt on the supposed sub-conscious origin of many such phenomena. The phantasms produced by crystal-gazing, for instance, are explained by those who believe in the existence of conscious states dissociated from the normal upper consciousness of the individual, as the product of sub-conscious automatism which the transparent

medium brings to the ken of the upper consciousness. Newbold did not find this assumption necessary to explain the results obtained in twenty-two cases whom he investigated. He used a glass ball, though he found that a glass of water, or a mirror reflecting a white surface, would do as well, but the brighter the surface the better. After a few minutes the subject usually begins to see a cloud which develops into a picture, often brightly coloured. The medium, Newbold remarks, "gives the patient a vision of unfilled space, and its function appears to be simply that of an irritant to the highly organised visual mechanism." The visions are frequently drawn from the subject's recent experience, but are often unrecognised. Like most hallucinations they are independent of the ideas in consciousness and seldom affected by suggestion in the waking state, though readily amenable to hypnotic suggestion. Newbold sees no reason to suppose that we have here brought to view a permanent independent sub-conscious realm existing in every person. We seem usually to be dealing with a mere temporary creation, formed of more or less dissociated mental elements to which we have "set the switches." In a similar way Newbold explains the auditory hallucinations sometimes produced by a continuous but indeterminate stimulus, such as running water, or a sea-shell, or chronic inflammation of the inner ear. He is also convinced that automatic writing is in many cases produced similarly by an indeterminate stimulus to the highly organised writing mechanism, and is essentially a pure motor phenomenon. In this connection he brings forward an interesting case which he was able to watch from its earliest development. The patient was an educated man with some knowledge of psychology, and had been dabbling in spiritualistic experiments. While sitting with friends round a table, waiting to see if levitation of the table could be obtained, he felt a strange motor disturbance, first in the left, then in the right arm and hand. Paper was procured and a pencil, with which the hand pounded away without producing anything legible. Subsequently the hand learned to write, the communications professing to come from the patient's deceased friends, a claim readily disproved to the patient's satisfaction. He could always control the hand, though it seemed to be moved by a power not his own. The thoughts were very like his own, but were not consciously furnished by him. Sometimes he knew what was coming, sometimes not. The patient was naturally alarmed, especially when the contracture of arm which preceded the writing began to appear very frequently and to spread to the muscles of the other arm, the legs, and finally the face, producing a general motor hysteria. It seemed to him that he was struggling, like the possessed of old, with a secondary personality which was striving to over-master his upper self. Newbold would himself have accepted this theory had he first seen the patient at this stage. But careful analysis

of the case, as he shows, makes this interpretation erroneous. The original invasion was probably a fatigue convulsion, due to the hands having been long outstretched on the table, such as frequently occurs (though not usually so violently) under similar conditions. The continuous but indeterminate stimulus applied to the centres produces in time a reflex response. The automatic contractions were turned in the direction of spirit-writing, simply because the subject's thoughts had been turned in that direction, and the whole process was furthered by auto-suggestion. It is noteworthy that the hand never wrote intelligibly when the subject refused to attend to the writing. Newbold does not attempt to explain the progressive central disorganisation, but it was primarily motor, and a few days' rest with antispasmodic treatment put an end to it, and all spontaneous symptoms disappeared. The case is an instructive one, and the paper altogether is suggestive in its interpretation of a large group of psychic phenomena.

The Mental and Physical Development of Children.

The precise influence of puberty on development is a matter of considerable practical importance concerning which our ignorance is still great. Dr. J. A. Gilbert has recently carried on an investigation into this matter which is of considerable value. (Studies from the "Yale Psychological Laboratory," Vol. ii., 1894.) He worked in Dr. Scripture's laboratory, taking children, boys and girls, from 6 to 17, one hundred at each age. His paper is elaborate and illustrated by some thirty charts. Among the tests chosen were muscle-sense, sensitiveness to colour-differences, force of suggestion, reaction time, voluntary motor ability, and fatigue. It is impossible to summarise his results here, but a few points may be mentioned.

In voluntary motor ability there is considerable falling off both in boys and girls from 12 to 13 (though throughout boys show a higher rate than girls). The boys regain their lost footing at 13, the girls not till 14. Gilbert considers that this contradicts the statement of Burnham that at puberty there is a great increase of vitality and energy as also greater mental activity, the former being undoubtedly true but the latter very doubtful. His curves seem to justify the opinion of Lange that physical development absorbs the strength and retards mental development. But, however that may be, the children under all his tests laboured under some disadvantage at about 13. He also finds a marked turn in a child's life at 7. In voluntary movement, boys tire more quickly than girls, but not more easily; i.e., the girl's movements, though much slower, are somewhat more sustained.

Gilbert is not able to agree with Porter that the brighter the child the taller he is. Porter decided brightness by mere examination tests. Gilbert found no such relation when a wider basis

of ability is adopted. He found that reaction time, however, is quicker in bright than in dull children, and throughout quicker in boys than in girls. The significance of this fact, if it is a fact, cannot be hastily assumed, and observers are by no means agreed. Boys are, throughout the tests, shown on the whole as superior to girls. In discrimination of colour-differences alone, girls have a slight advantage. At the age of 11 all children are on the average of about equal ability. Puberty has little disturbing influence in the development of discrimination in colour differences, but a great disturbing influence in tests involving quickness and accuracy of action. Hence, Gilbert concludes, puberty has a greater influence on the mental than on the physical development, and this is more noticeable in girls than in boys.

The Education of Muscular Control.

In the same volume of studies we find a record of some interesting experiments by Dr. Scripture, Miss T. L. Smith, and Miss E. M. Brown to ascertain the influence of practice in increasing steadiness of movement. The experiment consisted in inserting a needle into a twist drill gauge without touching the sides of the hole, any such contact being counted as an error. The results, which have some significance as regards the education of the defective classes, may here be simply recorded:—(1) Steadiness of movement may be increased by practice. (2) This increase is not limited to the control of the muscles immediately trained, but affects the muscles on the opposite side of the body also; practising the right hand develops the left also. (3) This training seems to be of a psychical rather than of a physical order and to be principally in the acquisition of steadiness of attention.

I may refer here to an interesting investigation by Mr. J. A. Hancock, of Clark University, into motor ability in children, which has led to allied results ("Pedagogical Seminary," Vol. iii., No. 1, 1894). Mr. Hancock studied a considerable number of children between the ages of five and seven in the schools at Worcester, Mass. He found that 110 children were steadier with the eyes open than closed; 48 were steadier with the eyes closed; in two there was no difference. The ataxiagraph was used. Although as children are shorter they ought to sway much less than adults, the reverse is the case. The girls are steadier than the boys (attributed to the earlier maturity of girls). Hancock found that it was impossible, however much persuasion was used, to make children hold their attention to the index finger for more than half a minute, and he points out the close connection between muscular control and attention. Sturgis's test for choreic tendencies showed that but half of 150 children tested were free from them; this he considers a point of great interest and importance. It was also found that 38 out of 150 when walking with closed eyes dragged their feet or kept them far apart. There is a general lack of con-

trol, especially over the smaller muscles, and efforts to keep quiet produce strong symptoms of nervous irritation, the inhibition being imperfect and resulting in awkward swayings and twitchings. "Children in normal healthy growth show a lack of co-ordination and control, paralleled only by ataxic, choreic, and paralytic patients."

The Theory of Emotion.

The clear understanding of emotion is of such great importance in psychological, and especially psychiatric work that attention may be drawn to two able articles under the above title by Prof. Dewey, of Chicago University ("Psychological Review," Nov. and Jan., 1894-5). Prof. Dewey defends and expands the James-Lange theory of emotion, combining it to some extent with Darwin's view of emotion. He argues that the so-called "expression of emotion" must be accounted for by reference to movements having some use, either as direct survivals or as disturbances of teleological co-ordinations. He shows that many of the facts are utterly inexplicable on the central theory, and can only be explained on the (James-Lange) discharge theory. This point of view means that, for instance, the mere *act of seeing* a bear sets up certain other acts in us, by habit, whether inherited or acquired. "If every emotional attitude is referred to useful acts, and if the emotion is not the reflex of such acts, where does it come in, and what is its relation to the attitude?" The discharge theory "does for the emotions precisely what the theory of evolution does in biology," involving an entirely new classification; and he hangs on the theory to the old Platonic and Aristotelian idea that feeling is the internalising of activity or will, and finds a crude anticipation of James in Hegel. To sum up: "Certain movements, formerly useful in themselves, become reduced to tendencies to action, to attitudes. As such they serve, when instinctively aroused into action, as means for realising ends. But so far as there is difficulty in adjusting the organic activity represented by the attitude with that which stands for the idea or end, there is temporary struggle and partial inhibition. This is reported as *affect*, or emotional seizure. Let the co-ordination be effected in one act, instead of in a successive series of mutually exclusive stimuli, and we have interest. Let such co-ordination become thoroughly habitual and hereditary, and we have *Gefühlston* [affective tone]."

Psychological Apparatus.

Messrs. Elmer G. Wilyoung and Co., of Philadelphia, U.S.A., have lately issued an illustrated catalogue of psychological instruments, which may be commended to scientific students of psychiatry. The catalogue runs to fifty pages, and describes several hundred pieces of apparatus. They have mostly been devised by well-known American teachers of psychology, such as Profs. San-

ford, Münsterberg, and Jastrow, more especially Dr. Scripture, who is responsible for a very large number of instruments here included. Among these I may mention apparatus to illustrate the fundamental phenomena of reaction time, vision, taste, smell, etc.; a steadiness gauge to measure accuracy; a device for recording steadiness of tongue; a hypnotism apparatus for inducing the hypnotic state by strain of the eye-muscles; audimeters, dynamometers, æsthesiometers, etc.

The various instruments devised for use in the psychological laboratory by Prof. Jastrow can now be obtained from the Garden City Model Works, Chicago. They are mostly simple and practical in character, and moderate in price. They include æsthesiometers, pressure attachments (for determining the pressure-sense of the skin), test weights, speech key (for giving verbal stimuli and making verbal reactions), temperature apparatus (for testing temperature sense), memory apparatus, and the automatograph. There are also various reaction instruments, including a very simple reaction key by means of which a slight contact ensures the opening or closing of a circuit by simply touching, preventing the frequent loss of readings of the chronoscope due to failure of the subject to maintain the contact. Catalogues and particulars may be obtained from the Garden City Model Works, 124, Clark Street, Chicago, Ill., U.S.A.

ASYLUM REPORTS.

English County and Borough Asylums.

Hants.—This asylum is so overcrowded that eighteen patients sleep in the Medical Superintendent's house. Relief will soon be gained by the opening of the idiot blocks, and later on by the removal of the Isle of Wight patients to an asylum building for the island. Typhoid fever has appeared under indefinite circumstances—that is to say, cases have appeared at intervals, some in new and some in old buildings. They were all on the female side. The water, drains, and milk are above suspicion. The Commissioners remark, *inter alia*, that the warm air supplied to the wards is possibly open to contamination. The air inlet gratings are level with the ground, and the chambers beneath are lined with absorbent bricks, which may derive from the adjacent soil whatever it contains, and communicate it to the air passing over them. Whether this fact has any bearing on the cases or not, it is quite worth noting. In many of the dormitories the cubic space has been reduced by overcrowding to 350 feet per patient. This will probably account for a somewhat high death-rate from phthisis.

Kent. County.—The chief feature of that portion of the report which deals with Barming Heath is the battle royal between the

Commissioners and the Committee on certain defects mentioned by the former at their visit. The latter responded by explaining away or traversing most of the statements, and a rejoinder on each side completes the matter as far as the present. Both parties seem skilled both in offence and defence, and it is not for us to intervene. Still, we cannot forget that the Committee have the heritage of much ancient, and in our present lights unsuitable, building, and should earn the more glory when they have overcome the difficulties of the situation. At the Chartham Asylum Dr. Fitzgerald notes that an attempt was made to discharge some quiet and harmless men and women to the unions, but with very limited success.

London. City.—Dr. White reports that his Committee have taken such a just view of the value of the Association's Nursing Certificate that they have given each successful candidate a silver badge bearing the City Arms, with ribbon of City Colours, in lieu of the Association's badge. We see with pleasure that the services of the medical staff have been acknowledged by the substantial addition of 25 per cent. to former honoraria. The private patients, each paying a guinea per week, numbered on December 31, 1894, fifty-seven, and gave a considerable profit.

Lancashire. Prestwich.—As our readers will probably remember, the experiment of sending patients to the specially-prepared wards of a Workhouse under sect. 26 of the Lunacy Act was initiated here, and remains, we believe, the sole instance. It seems to work well, with proper selection of cases. That these are well-chosen is shown by the fact that only one case has been returned to Prestwich as unmanageable. Of 617 admissions 114 were general paralytics, 316 cases of mania of all sorts, and 230 of melancholia, with four cases only of dementia, and 23 epileptics and congenitals. These figures show what a pressing demand there is for accommodating moving cases. At the time of their report in May the Commissioners noted that there were only 26 vacancies in the four huge asylums in this county, with no prospect of further asylum accommodation being ready for years to come.

We note the reported recovery of one female general paralytic.

Monmouth, Brecon, and Radnor.—A dissolution of unions between these counties, or some of them, was reported as pending, but this could not take place before severe overcrowding would be experienced. This is by no means the only case where inconvenience has arisen from delaying till the last moment the steps necessary, but we cannot wonder at the delay, looking to the enormous expense thrown suddenly on a county which from having entered into union with others cannot be either rich or important. The proportion of contributed money paid out to it by its quondam partners goes but a small way towards the establishment of an independent institution. Dr. Glendinning reports that the length of service of the male attendants is gradually increasing, this

being brought about by higher wages and lodging money to the married men. He calls for a pension scheme to further this desirable improvement.

Newcastle. Borough.—To the carefully-kept statistics of the ordinary tables Dr. Callcott adds a new one, which we believe is quite original. In it he gives the weight on admission and the weight on leaving of each patient discharged as recovered during the year. No constant rule can be deduced therefrom, but it seems to have been very generally the case that the shorter duration of residence was accompanied by the greater increase. For instance, 6st. 9lbs. became 8st. 9lbs. in five months and 24 days; 6st. 11lb. rose to 8st. 2lb. in two months and 14 days, while 32 months' residence in another case resulted in the loss of 11b.

The relative amount of melancholia cases admitted is very small, being nine cases in 116.

Northampton. County.—The profits from out-county and private patients have met all claims on the building and repairs account, and the asylum has handed over in the year £2,222 to the County Council, making a total of £8,323 in the last six years.

A feature of the institution is the children's block for both sexes attached to the women's wards, where great attention is evidently paid to the improvement of mind and habits. Four are stated to have been discharged recovered, though on consulting Table VIII. we cannot find that any child under fifteen is thus reported.

Nottingham. Borough.—Mr. Powell notes that 10 cases in 178 admissions were directly attributable to influenza, and he believes that this disease will in the future become a very potent factor in causation. The number of melancholic cases admitted is considerably above the average.

The holders of the Association Certificate each receive £2 extra wages per annum.

Salop and Montgomery Counties.—Dr. Strange, of whose recovery from serious illness we are glad to be informed by the report, relates the following extraordinary occurrence, which well illustrates the endlessness of the trials and troubles to be met with in the care of the insane:—

Only one inquest was held. The circumstances of the death were very peculiar. A female private patient, partly demented, was sleeping in a single room in No. 2 Ward. On the night of September 23rd she was visited, as usual, by the night nurse every two hours, and at the last visit, a little after four a.m., she was sleeping quietly in bed. When the day attendant went to get her up a little after six o'clock she found the bed empty, the patient's clothing, which should have been in her tin box, strewed about the room, and the patient in the box apparently dead. The dimensions of the box were only two feet by one foot four inches, by one foot four inches. This patient had never shown any suicidal tendency, nor is it likely that if she contemplated suicide she would have carried out her intention in this way. She was in the habit of secreting herself in places, and the only possible explanation is that she got into the box under some insane idea of hiding when she was called, and the lid fastened down accidentally and shut her in, and suffocated her.

Somerset County.—Dr. Wade, in describing the difficulties caused by the admission of many serious cases into an already overcrowded asylum, states that 24 of the suicidal admissions had made actual attempts on their own lives. He is very dissatisfied with the state of the law concerning would-be suicides.

Two of these had been arrested and charged before the magistrates, and as their cases illustrate what I venture to consider the very unsatisfactory state of the law on the subject, I will briefly allude to them.

1. A. D., while the subject of mental depression, made an attempt to destroy himself by cutting his throat. He was removed to the hospital, and on his discharge therefrom was taken before the magistrates and committed for trial, *being admitted to bail*. He was in due course tried for the offence, found insane at the time of committing it, and ordered to be detained during her Majesty's pleasure. When received into this asylum he was found to be quite sane, and on representation being made to the Home Secretary he was conditionally discharged. The proceedings in this case were no doubt strictly in accordance with the law, but were not very logical. The object of detaining a man during her Majesty's pleasure is, of course, to prevent him from doing harm to himself or others. But if this man was fit to be out on bail it was hardly necessary to detain him during her Majesty's pleasure.

2. J. P. was tried at Quarter Sessions for attempted suicide, and sentenced to three months' imprisonment. On his discharge from prison he was removed to the workhouse, when, his insanity being recognised, he was sent to the asylum. In this case a lunatic was sent to prison just when it was important that he should be placed under care and treatment.

These and other cases that have occurred from time to time suggest the consideration of the present law, and the question, Is it just and is any good gained to society by it? I venture to think that punishment of attempts at suicide is useless, inasmuch as it fails to prevent sane men from committing self-destruction, and harsh, as it is frequently inflicted on the insane, who are thus removed from treatment just at a time when such treatment is most likely to be of service.

We note that no less than five cases (in 227 admissions) were discharged as "not insane." Surely a high proportion.

Staffordshire. Burntwood.—Dr. Spence is a little doubtful whether much success will attend the desired extension of the grant of 4s. to cases returned to workhouses from asylums, even if it be adopted. He fears that the union authorities will object to any case that gives the least trouble, and he also states that there are but few workhouses in that county where such accommodation is provided as would satisfy the requirements of the Commissioners. No doubt this is true as matters stand now, but it must be remembered that the number, both of doctors and nurses, who are competent to attend to quiet chronic cases is steadily increasing, and that public opinion is being kept constantly stirred up by continued demand for fresh and expensive asylum accommodation. It is not too much to believe that any opportunity of obviating further burdens will some day lead Guardians to put parts of their workhouses in proper repair to keep suitable cases near home. Dr. Spence, with a view of improving the "causation" tables, issues printed papers of queries to Relieving Officers and others, but

notwithstanding these and other attempts to obtain information, cannot look on the table as satisfactory.

Sunderland Borough.—This new asylum commences its history with an interim report, which, by reason of recent birth, does not contain the Association tables. No doubt we may rely on such an energetic Superintendent as Dr. Elkins giving his loyal support in this direction when he has accumulated a whole year's figures. Mr. Hine, now well known to the Association by his constructions all over the kingdom, considers that a record in asylum building has been established. His competition design was selected in February, 1892. After it had been passed by the Commissioners the tenders for the foundations were obtained in September of that year, and finally the asylum was opened in May, 1895, more than a month before the guaranteed date of completion. The cost per bed is not given, as the accounts are not yet completed, but Mr. Hine states that in the aggregate it will not exceed the contract amounts, as extras have been balanced by omissions. We wish Dr. Elkins success in the management of his asylum.

Sussex County.—Notwithstanding that East Sussex, the present proprietor of Haywards Heath Asylum, has shed off West Sussex, the increased demands from its own territory and from Brighton again threaten to swamp the accommodation. The Committee has reported to the County Council their opinion that there should be at once provided (a) a hospital for acute cases; (b) additional accommodation for paupers; (c) special accommodation for idiots and imbeciles; (d) accommodation for private patients. We hear, however, that, though these proposals have met with a favourable reception, the present financial arrangements between East Sussex and Brighton are such as to render the former unwilling to expend more capital on the asylum until such arrangements have been reviewed. There is therefore a distinct chance of these two authorities having the pleasure of contributing to the profits of other counties, even if they should be lucky enough to find vacant accommodation when the pinch comes.

Warwick County.—

For my own part, I freely admit that I know of nothing which is more likely to be productive of benefit to those under our care than this education and raising of the status of those to whom we are necessarily obliged to depute the carrying out of our treatment.

Classes of instruction have been held annually in this asylum for four years.

Between 40 and 50 Certificates of the St. John's Ambulance Association have been obtained, and a large class is at present studying for the Certificate of the Medico-Psychological Association, which is obtained by passing an examination on paper and *viva voce*. The former part of the examination has, I feel sure, prevented many from entering their names, and for my own part might, I think, be excluded with advantage.

While cordially endorsing Dr. Miller's views as to the necessity for raising the status of attendants, we cannot agree with his suggestion to omit the written part of the examination. No doubt

many old attendants are debarred thereby from entering the examination, but surely the necessity for being able to put their thoughts on paper on the part of younger attendants must raise the standard of knowledge. We trust that the authorities will never be induced to relax the regulations in this respect.

Worcester County.—Judging from the reports of the Committee and Commissioners things seem to go well and in perfect harmony in this asylum. We are especially glad to see the complimentary remarks written by the Commissioners on the bright and cheerful state of the wards, for they coincide exactly, we hear, with the observations made by the members of the Association who attended the successful general meeting in Worcester last year, when the hospitable arrangements made by Dr. Cooke made the scientific programme more than usually digestible.

Among the causes of insanity (Table X.) we note that 25 admissions in 189 were epileptic, and that 60 had had previous attacks. Both these proportions are considerably in excess of the Commissioners' five-year averages. On the other hand, nine cases only were due to alcohol, and in 23 cases only was the alleged cause returned as unknown. We also note that Dr. Cooke has the courage of his opinions in assigning general paralysis as a physical cause of insanity. Of these cases there were eleven, six males and five females. We do not remember to have hitherto noted such a high proportion of female paralysis.

Yorkshire. Wadsley.—In this asylum, fed as it is by such large and busy centres as Bradford, Leeds, Sheffield, etc., a larger proportion of general paralytics than seven per cent. of the admissions might have been looked for. On the other hand, however, there were 329 epileptics in an average residence of 1,582, being over 20 per cent. Intemperance in drink was responsible for 65 in 444 admissions and sexual intemperance for nine cases, the latter being much above the average.

English Hospitals.

Virginia Water.—A considerable item in this report is a statement by Dr. Phillips of the unfortunate case which has been so thoroughly discussed and thrashed out in every conceivable way. It would indeed be pleasant to record that the last word had been said about the matter, since every lesson that can be taught has been long ago learned. Further criticism must necessarily be considered to be largely personal spleen.

Wanford House.—The medical report is made and presented by Dr. Morton, on whom had devolved the superintendence of the asylum in consequence of Dr. Deas' absence, the latter being brought about by lamentable accidents. Dr. Morton notes a rare occurrence. A gentleman developed spontaneous gangrene of the leg, and a fortnight later a lady, aged 73, suffered from a similar

affection. In each case amputation was necessary, the subsequent course of the cases being satisfactory.

We are pleased to see by the Committee's report that the financial position of this most useful institution has materially improved since we touched on the subject two years ago.

York Retreat.—Dr. Pierce in his report makes, in very appropriate terms, mention of the loss which this institution has suffered by the death of Dr. Hack Tuke. The latter's first connection with it was just fifty years ago. Among the recoveries was a case of melancholic stupor after 16 months' residence. For many months she required feeding with the tube.

Many alterations and improvements have been carried out, and it is gratifying to see that financially matters have been going the right way, as we gather from Dr. Pierce's report. The usual financial statement is not published this year.

Scottish District Asylums.

Argyll and Bute District.—In the report of the Visiting Commissioner we find the following :—

Considerable progress has been made with the addition to the asylum. When completed it will accommodate 34 men. All the mason, carpenter, plaster, and plumber work, and all the painting will have been done by patients and artisan attendants. They will have done everything except the slating, a part of the work on which it would not be safe to employ patients. This is believed to be the largest piece of work which has been executed by patients and their attendants in Scotland. That such a thing is possible reflects most creditably on the management.

It seems ungracious to pick holes in conscientious work bestowed on the preparation of the Association Tables, but we feel impelled to question the subdivision of Table III. adopted by Dr. Cameron. He has continued the laborious practice, no doubt handed down to him, of providing a separate table for each of the two districts of Argyll and Bute. On adding the main factors together we cannot make them fit with the figures running through all the other tables. On looking about, however, we recognise that in addition there are a considerable number of private patients who are here ignored, and therefore Table III. in no sense represents the total operations of the year. We suggest that it should, for while probably there are few local digesters of figures to be benefited by such subdivisions, there are plenty of general readers like ourselves who do take note of statistics. By a curious but obvious error the percentage of deaths on average residence is given in the principal division as 32 for 1893 and 16 for 1894, the fact being, as stated in the body of the report, that the death rate was in 1893 7.1 and in 1894 as low as 3.3.

Barony Parochial Asylum, Lenzie.—No less than 29 unrecovered cases were discharged in 1894 to the care of relatives, and 43 were boarded out with private guardians. It could be wished that cir-

circumstances and prejudices permitted this system being widely adopted in England. The admissions were 446 in number, being over 70 per cent. of the average number resident. We would suggest that Table X., showing the alleged causes, should be brought into the form adopted by the Association. As it stands now it is difficult to collate, which, dealing as it does with the largest number of admissions in Scotland, is to be regretted.

Barony Parish Inspector of Poor.—We are glad to have received this, as it enables us to collate with the foregoing and give a few facts about dealing with pauper lunatics. The figures given are for only part of the time included in the Lenzie report. From these and from a very able statement appended from Dr. Carswell on the certification of lunatics in the Barony Parish for the year ending May, 1895, we learn that out of a population of 300,000, as estimated by Sir Arthur Mitchell, 338 applications were made to the Inspector of Poor on behalf of persons supposed to be insane. Of these 213 were certified and 125 escaped the ordeal. Of the latter 79 were treated in the observation wards at Barnhill Hospital, with the result that 77 were discharged recovered and two died. In addition seven cases were kept there but a short time, and were then certified and removed to the asylum. For a fuller study of the beneficial functions of these observation wards we refer readers to the "Journal of Mental Science," July, 1894, which contains a paper by Dr. Carswell, and a prolonged debate on the subject. In addition to those treated in Lenzie and in the observation wards there were at the time of report 215 harmless patients boarded out, viz., 15 at Larbert Institution (idiots?), 16 with friends, and 184 in private dwellings. Of course there is one great danger in boarding so many outside institutions—the danger of neglect. But here every precaution seems to be taken.

It will be remembered that the Barony Parish was selected by Sir Arthur Mitchell as the ground for his invaluable memorandum on the question of increase of insanity. The reason for selection is thus stated by Dr. Carswell:—

He selects the Barony Parish as a suitable area for the purposes of investigation, because, among other reasons, during the ten years 1883-92, the social condition of the Barony population was steadily prosperous, there having been no bursts either of depression or prosperity, and also because the possession of sufficient asylum accommodation, neither too great nor too limited, kept the parochial administration free from the temptation either to exclude from the benefits of asylum care and treatment patients who might thereby be benefited, or, on the other hand, to crowd into their asylum patients for whom asylum care was not necessary.

City of Glasgow, etc., District. Kirklands Asylum.—Dr. Campbell Clark having participated in the great shuffle of cards in asylum work in and around Glasgow, has gone to Hartwood, his Committee parting with him with expressions of regret. Dr. Sheen has taken his place, and issues his first report. A table is given of the results of Dr. Clark's fourteen years' work there,

which shows a percentage of 42·4 of recoveries. There were boarded out 12 per cent. on the admissions, and 75 per cent. of those so treated managed to remain outside the asylum; 12 per cent. of the admissions were general paralytics—not a high proportion for such a busy collecting area as this asylum has.

Govan Parochial Asylum.—Dr. Watson having been appointed to the new Hawkhead Asylum, is succeeded by Dr. Richard. Among the otherwise very carefully kept statistical tables we do not find the usual No. XI, showing the form of insanity in those admitted.

Midlothian and Peebles.—Dr. Mitchell states that among the admissions there were three brothers on different dates, whose mother and uncle are likewise insane. One man, a foreign sailor, had tried to drown himself before admission, the suicidal impulse coming on him after at least fifteen years of latent insanity. We are glad to see that an Assistant Medical Officer is to be appointed, since there will now be an opportunity for the preparation and publication of the Association's Tables, without which the report appears lopsided.

Roxburgh, etc., District.—Pressure on the accommodation has necessitated the procuring of plans for an addition of fifty beds to the female side of the asylum. A very severe epidemic of influenza indirectly lead to a high death-rate. We note that, possibly from this cause, six general paralytics died, one only being admitted, and two remaining at the end of the year. The lamentable scarcity of water, which continues in spite of the labours of the Committee and of the thunderings of the Commissioners, suggests great carelessness in prospecting when the site of the institution was first looked out. Dr. Carlyle Johnstone is philosophically thankful that “the past season was a wet one, and the institution escaped with less of dirt and danger than usual.”

Scottish Chartered Asylums.

Dundee Royal Asylum.—We cull from Dr. Rorie's report the following graphic description of certain folk well known to most of us:—

The persons I now refer to ought probably to be classed with the habitual offenders, and generally are admitted from the prison or from the police office. Although probably too weak minded to be suitable for prison discipline, they are certainly in many instances too sane for detention and treatment in an ordinary asylum. They refuse to engage in any form of occupation, declaring they had not been sent to the asylum for that purpose; they frequently attempt to pick the door locks, and often succeed in doing so, this being no difficult matter; but the most striking feature is that they often combine in these efforts, a procedure of very rare occurrence amongst the ordinary insane.

Gartnavel Royal Asylum.—Dr. Yellowlees is apparently quite a connoisseur in the matter of feeding patients for years. If we remember right we noted another such case of his in a former review. It is a comfort to those who are not yet convinced that means of

treatment of a respectable age must be thrown on one side completely, to have the practical and successful example of Dr. Yellowlees.

One of the recoveries was so remarkable as to deserve special notice. The man, age 38, was admitted in January, 1888, in consequence of religious excitement connected with a Jubilee Mass which had just been celebrated by the Pope. Two months after admission he became utterly indifferent to things around him, ceased to speak and to perform any voluntary act of any kind, and required to be fed by the stomach-tube. All attempts to arouse him were futile, and the tube-feeding was of necessity continued thrice daily for four-and-a-half years thereafter; for another year he was fed by the spoon; at length, in the end of 1893, he began to awake from his long insanity, spoke, fed himself, and was able to walk about; and in April, 1894, was discharged recovered.

This is the third case of this kind which has occurred here. In the other cases—both women—the periods of tube-feeding were respectively eight-and-a-half years and three years. Although this patient could recall many things that had occurred in his presence during his illness, and said that he had often heard me assure the students that he would recover, yet it was disappointing to find that, as in the other similar cases, he was quite unable to analyse or to explain his behaviour in any satisfactory way. He could only say that he felt it a solemn and imperative duty not to eat, but when he found no special benefit coming to him thereby, he thought he might as well eat like other people!

James Murray's Royal Asylum, Perth.—In commenting on a case of recovery after six years of residence, Dr. Urquhart writes:—

These events are rare enough to merit special mention, but we can refer to three within recent years in which the duration of the disease necessitated residence of six, eight, and three years respectively.

The occurrence of such cases causes us to hesitate when we are asked to subscribe to the opinion that divorce should be granted on account of "incurable" insanity. The recovery of these patients appeared to be extremely improbable, yet recovery has not only ensued, but remains permanent after the lapse of years.

Dr. Urquhart is a firm believer in the policy of developing self-restraint by granting every possible liberty, and at date of report is able to say that 56 patients out of a total of 112 are on parole. There has been no escape during the year, and it has only once been deemed advisable to withdraw parole, except in recurrent cases where at certain times unfitness for parole is temporarily manifest.

Irish District Asylums.

Belfast.—Overcrowding, pending the splitting up of the district and consequent provision of another asylum for County Antrim, has led the Governors to put 112 quiet chronic cases in the Ballymena Workhouse, under provisions which seem to correspond exactly with those of Sect. 26 of our Act. Further, the authorities have had "go" enough to purchase a neighbouring demesne of 300 acres, with a fine house, which, with a little modification, will take in 75 male patients.

The general paralytics number 2 admissions, 1 death, and 5

remaining, the corresponding totals being 215, 45, and 750. Intemperance was assigned in about 5 per cent. of the admissions.

Cork.—The training of nurses and attendants for the Association's certificate is carried on thoroughly. The following remarks of Dr. Oscar Woods are valuable:—

"Hereditary influences" are only assigned in 22 cases. This information is always reluctantly given, but I have frequently traced it when it has been altogether absent from the committal; the same may be said as regards intemperance, which, as a cause of insanity, is not decreasing, especially in relapsed cases and those having a hereditary predisposition; in such cases a very moderate amount of stimulant acts as an exciting cause. The tendency of the day is centralisation: towns are filling up, while the country population is decreasing; thus, the mass of the people are brought under conditions not so favourable to health. I cannot give a better example of the effect of this than to cite the proportion of lunacy in the County and City to the population. While in the

County it is	1 in 411
City it is	1 in 231

Proportion for admissions of the year—

County ...	...	1 in 1,696
City ...	...	1 in 691

General paralytics numbered 2 in 313 admissions, 1 in 91 deaths, and 4 in 1,207 remanets.

Down.—Dr. Nolan's views on the apparent increase of insanity are very interesting. He says:—

Admissions:—The phenomenally high number of admissions—159—higher than any other since the opening of the asylum in 1869—must not excite alarm as indicating a proportionate increase of insanity in this county. It is probable, indeed, that a very small absolute increase of mental disease underlies the figure, which is 42 in excess of the number admitted in 1893. The influx of patients may be fairly taken as indicating the extension of more enlightened views regarding the nature and treatment, rather than as a rapid growth, of insanity. Investigation of the antecedents of the patients admitted during the twelve-month under review supports this opinion, as careful inquiry brought to light a history of heredity in 33·3 per cent., many having had two, three, or more relatives insane, *a large proportion of whom had never been certified lunatics*. When we consider the very imperfect family histories obtained from the class from which our patients are drawn, and the reticence that holds back information on the important point in question, it may be safely assumed that the percentage arrived at is very much under the real number of those in whom hereditary taint is accountable for insanity. Moreover, in very many instances one or more of the insane ancestors have never been treated in any institution for mental disease. But nowadays the Hospital for Mental Disease is quite as much appreciated by the relatives of the afflicted, and in no small proportion by the insane themselves, as the "mad-houses" of old were abhorred. Though seemingly paradoxical, it is nevertheless true that the wiser we grow the more insane shall be found in asylums.

General paralytics numbered 6 in 159 admissions, 5 in 50 deaths, and 5 out of 501 at the end of the year.

Kilkenny.—A severe epidemic of pneumonia caused just one-half of the 26 deaths. This was in the spring of the year. It would be interesting to know what was the cause. The average age of these deaths was 61.

No admissions nor deaths were due to general paralysis, and only two of the 346 residents at the end of the year suffered from this disease.

Limerick.—A great necessity exists here for increase in the amount of land for cultivation by the patients. The Governors are apparently afraid of hiring the only ground available on account of a railway crossing it. But the Inspector plainly tells them to discount this, as it is of no hindrance in other places, and puts on the screw thus:—

Under such circumstances the Board of Control, on whom the ultimate responsibility of providing sufficient land rests, will have to consider in connection with the additions to the asylum so admittedly necessary, whether it does not lay on them as a statutory duty to increase the asylum estate. If it should be decided to do so, I venture to hope that the Board of Control will carry with them the approval of the Governors, who have at all times shown such an intelligent and liberal interest in the treatment of the insane poor of the district.

It would not, perhaps, be a bad thing in some English districts if the Commissioners had a little of the large amount of power which their Irish colleagues have.

In other directions the Inspector speaks highly of the determined efforts made to overcome the long-standing defects of the buildings.

No paralytics were admitted or died or were left at the end of the year.

Londonderry.—No general paralytic appears in any of the statistics. Dr. Hetherington reports that neither restraint nor seclusion was used during the year. The Inspector noted with satisfaction that at the time of his visit no one was in bed from violence or excitement, that there were no wet beds on the previous night. We note that the recoveries were 46·87 on the admissions, and the deaths 8·12 on a daily average residence of 418. Such facts can hardly be regarded in any other light than affording the best evidence of the best asylum management.

In concluding the review of the only six Irish reports which have reached us we feel that it is our duty to acknowledge the immense improvement that is taking place in Ireland. It seems as if a great wave of progress had passed over. In all the reports one can see on the part of all, whether Governors, Officers, or Inspectors, the best possible spirit. The points of defect, which used to be all too many, have been, or are being, systematically attacked and overcome. It is not too much to suppose that as both directly by order, and indirectly by its large share in contributing the necessary funds from State income, the "Castle" can influence enormously the asylum system, enlightenment in this direction has crept in there, and may now be expected to increase.

THE PROGRESS OF PSYCHIATRY IN 1895.

FRANCE: By Dr. RENÉ SEMELAIGNE.

Legislation against Alcoholism.

The disastrous progress of alcoholism has roused public attention in France, as elsewhere. A special law has passed the *Chambre des Députés*, but has not yet been before the *Sénat*. This law ordains that the State shall exercise a monopoly of the rectification of alcohol; the maintenance of the privileges of distillers of brandy under the limit of 20 litres of absolute alcohol (40 litres of eau de vie of 50°); an increased taxation on the manufacture of spirituous liquors; the declaration of the manufacture of all essences or concentrated extracts used by the trade; the prohibition of all essences declared dangerous by the Academy of Medicine; a reduction of the tax on wine, cider, beer, etc.

Dr. Motet desires in addition two further measures—(1) the establishment of houses for the sale of the last-named class of beverages (hygienic) to working men; and (2) lectures for working men and others. Dr. Bergeron proposes to diminish the number of drinking shops, at present 460,000 in France and 25,000 in Paris, to increase the cost of licenses, and to grant them only after searching inquiry into the character of those applying for them. Dr. Magnan believes that asylums should be erected for habitual drunkards who are not insane, admission to be granted on a simple request without the formalities of certification. Dr. Laborde would prohibit the habitual use of all poisonous drugs, and would prevent the adulteration of alcoholic drinks by legal measures. He would further seek to reduce the consumption of spirits by moral and fiscal methods. Mr. Colin proposes the imposition of very high taxation on such alcoholic drinks as may be alleged to be dangerous poisons and the election of a scientific committee for the purpose of deciding with precision the properties of the various alcohols. Dr. Legrain demands the forfeiture of paternal rights by drunken fathers. Dr. Serieux's proposals refer to special asylums for the reception of insane alcoholics who would be committed as insane, and, on recovery from the more active symptoms, would be continued in detention for periods varying from six to eighteen months. He also proposes to deal similarly with habitual drunkards for similar periods, both voluntary patients and those admitted upon the request of a relative. Further, to confine without limit of time such alcoholics as are incurable and dangerous. Dr. Meilhon urges that the law should fix the price of all alcoholic drinks sold in public-houses, the price to be as low as possible in guaranteeing the purity of the manufacture, the penalty of infringing on these rules being a fine, with the risk of withdrawal of the license. By such an enactment, many drinking

shops would be obliged to shut on account of the meagre profits. Establishments for the sale of temperance beverages would be allowed greater profits, and Dr. Meilhon would suppress the privileges of distillers of brandy.

Lectures on the dangers of alcohol have been given in certain of the schools of Paris, and this is the first step for the suppression of the alcoholic plague. The French people too often expect everything at the hands of the Government. This kind of socialism, however, is most pernicious. Let us set about the business ourselves and success will follow.

Dangerous and Criminal Lunatics.

Dr. Ramadier, at a recent meeting of the Société Medico-Psychologique, reported the case of a patient labouring under persecutory insanity, who had been discharged by the Tribunal from asylum care. This was given effect to in spite of the adverse opinion of the Medical Superintendent and without any special examination, and the result was that on his liberation he attempted suicide and the Public Prosecutor found it necessary to replace him in the asylum. A similar case was that of a criminal lunatic who could not be tried on account of his insanity. He was placed in Ville Evrard Asylum under the certificates of Drs. Garnier, Le Grain, Magnan, Marandon de Montyel, where he soon claimed his liberty. The Tribunal discharged him and declared that he had never been insane. A gentleman of good position, suffering from senile dementia, was arrested and sent to prison for eight months without having undergone any medical examination. On my earnest solicitation, his mental state was investigated, and the result was that he was removed from the prison to an asylum. The magistrates in these cases acted in a very inconsiderate manner—sending the insane to prison and setting free dangerous lunatics. Dr. Marandon de Montyel is of opinion that greater care would be exercised if the whole responsibility of the commitment and discharge of lunatics were imposed upon the magistrates. In the opinion of Dr. Christian and Jules Voisin criminal lunatics should be kept in asylums not as a punishment, but because their liberation constitutes a danger to society. Dr. Charpentier is opposed to this idea, and cites the case of one of his patients who murdered his wife, and afterwards asseverated that he had no reason to kill anyone now that his wife was dead, although if she came to life he would certainly find it necessary to remove her again. Dr. Christian was of opinion that this objection was not valid, that the patient would marry again, and kill another wife, in accordance with the record of similar cases several times reported. The Congrès Penitenciaire lately adopted a resolution recommending (1) that the legal authorities should provide asylums or special divisions of asylums for the reception of such criminals as have been prosecuted and acquitted as insane; (2)

that before such persons are discharged they should pass under the review of the *Autorité Judiciaire*, *Autorité Administrative*, and the Medical Superintendent. The Congress also recommended that, in the case of a criminal who has become insane during his term of imprisonment, the time he might spend in an asylum should be calculated in the duration of the punishment imposed.

Congress of French Alienists.

At the Annual Congress two reports were presented, one by Dr. Ritti on the psychoses of old age, the other by Dr. Parant on the irresistible impulses of epileptics. Dr. Ritti dealt with those mental diseases which occur in the latest period of life in persons previously sane. In order of frequency, he described melancholia, mental confusion, mania, moral insanity, and systematised delusional insanity. He stated that the senile delusions of persecution progress more rapidly than in adult-life, and that nearly all the senile psychoses are characterised by eroticism. Their origin may be looked for in heredity, organic modifications, and the lessened resistance of a worn-out brain to moral ideas. The prognosis is not quite unfavourable.

Dr. Parant believes that epilepsy in itself does not constitute irresponsibility, but that epileptics may enjoy complete mental integrity; and, on the other hand, that the will may be perfectly annihilated, that the patient is not responsible, although conscious of his acts. Many other interesting papers were read, and the transactions are now published in detail. The next congress will be held at Nancy in August of this year.

Pathogeny of Epileptic and Apoplectic Seizures in General Paralysis.

In the opinion of Dr. Legrain these occurrences are consequent on auto-intoxication. In order to discharge these toxic elements he bleeds the patients copiously. Dr. L. Guerin supposes that there is an intoxication of the nervous centres superadded to the chronic destructive processes of meningo-encephalitis. These fits often follow on gastro-intestinal disorders or retention of urine, and are to be treated by purgatives and bleeding. Dr. Christian believes that they are merely functional (arterial obliteration), and finds good results from ergotin. He does not bleed his patients. Dr. Ballet urges that these troubles are caused by irritation of the cortical centres.

Treatment of Patients at Ville Evrard.

Dr. Marandon de Montyel has published the results of his treatment for the last eight years. Some 50 or 60 per cent. are usefully employed. Relatives of patients are admitted to all the wards from one till four daily, and are allowed to take the quiet and inoffensive patients beyond the grounds from morning till

evening. Pleasure parties or leave of absence for one or two weeks are rewards and recreations for suitable patients, and Dr. de Montyel sends out patients to their friends on pass, as soon as he is sure that residence in the asylum has produced its whole effect.

BELGIUM: By Dr. JULES MOREL.

Auto-intoxications.

Dr. de Boeck, in his Presidential Address, reviewed the progress of psychiatry, and specially referred to the work of Golgi and others, who have revolutionised our knowledge of the structure of the nervous system. In speaking of the action of the neurons, he dwelt upon the importance of their chemical composition, showing that abnormality in this respect might result in processes too slow or too quick, owing to insufficient nutrition or the introduction of foreign elements. Insufficiency of nourishment is already well recognised by alienists, but the introduction of foreign elements is not so widely admitted. These intoxications may be derived from other parts of the body, as a result of over-abundant excretory products, and are best named auto-intoxications; or they may be derived from organised matter, such as parasites, or poisons, such as alcohol. Little is as yet known regarding auto-intoxication, but the effects of myxœdema, uræmia, fatigue are admitted in this respect. It is mostly due to digestive derangements, accompanied by the formation of micro-organisms. Fermentative products are set free in the circulation, interfere with the nutrition of the neurons and eventuate in melancholic or even maniacal conditions. Bacteriological investigations have proved the pathogeny of malarial infections and the possibility of neutralising the power of living organisms in the human body, and we may, therefore, hope for good results in following out the teaching thus conveyed.

Science in Asylums.

Dr. J. Morel called attention to the small amount of scientific work done in Belgian Asylums, and blamed the ignorance and indifference of many of the Superintendents, whose position is not of a sufficiently high standard. He pleaded for the formation of a medical library, for laboratories, and for at least one Assistant Medical Officer in each asylum. He could not consider it satisfactory that there are only four Medical Superintendents in Belgium (Mons, Tournai, Gheel, and Liseaux) who limit their work to the asylums. The others have to engage in private practice owing to the insufficiency of their emoluments. Psychiatry is only taught in three universities, and there is no compulsion placed upon the proprietors of asylums to appoint physicians who have had a special education in medico-psychological affairs. Dr. Morel urged the necessity of amending these conditions, which are detrimental to the interests of the insane.

Mental Symptoms in "Tics Convulsifs."

Dr. Remonchamps has studied this malady, which was first described by Dr. Gilles de la Tourette. He believes that the obsessions of motion and speech are not completely unconscious. They may be restrained by the patient at some periods. Dr. Remonchamps referred to the analagous conduct of children, who are prone to repeat rare or indecent words, or to make faces. He concludes that the three capital symptoms of this malady (involuntary movements, echolalia, and coprolalia) are hereditary, but that, by the development of higher associations (voluntary ideation), these defects may be more or less removed.

The Toxicity of Urine in the Insane.

Dr. Marrant has followed up the numerous experiments of Bouchard and others by injecting urine into the blood circulation of animals, and has made a study of the toxicity of insane patients. The following are his conclusions:—Normal urine may kill animals in very different doses; the same urine possesses a very different toxicity when injected into various individuals of the same species; urine from an insane patient varies in toxicity from day to day, although the mental state remains unchanged; the resistance is apparently lessened after an animal has had several injections of urine; the urine of melancholic patients is sometimes less toxic than normal; the urine of neurasthenic patients is rather diminished in toxicity; the urine of stuporose and maniacal patients varied much, sometimes much more toxic, sometimes much less toxic than normal; the urine of some insane patients is practically normal. Dr. Marrant believes that no positive statements can yet be made, but he says that it is certain that those animals which passed urine or vomited during the injections were able to resist the toxic effects better than those which did not.

GERMANY: By Dr. J. BRESLER.

Hysteria.

Drs. F. Brewer and Freud have produced an important book ("Studien über Hysterie") on the origin and mechanism of hysteria, in which they set forth original views. They hold that every mental stimulation of violent intensity requires for its relief a discharge in the form of words, weeping, or act of vengeance. This reaction being strong enough, the cause disappears, and the memory of the painful idea is gradually dispelled by counter association. When such a painful idea is violently expelled out of the consciousness and the reaction is suppressed, the sum of the suppressed effect is transformed into somatic forms of disturbance, and appear as hysterical symptoms, pain, convulsions, contractures, anæsthesia, paralysis, etc. The authors have named these phenomena *hysterical conversion*. The disturb-

ance which was originally intra-cerebral is converted into an excitation of the peripheral nerves. The primitive emotional idea, which exists obscurely and acts unconsciously, does not evoke the symptoms which are manifest in the abnormal hysterical reflex. The memory of the painful idea, which is thus separable from the effect, exists only briefly in the "hypnoid" state to which the individual is disposed, or which is produced by the disturbance itself. In the hypnotic state the recollection of the psychical disturbance is strongly evident, the effect is connected with the painful idea (while the patient is confidentially relating his troubles). The separation of this idea from the other normal contents of the whole consciousness no longer exists, and the hysterical symptoms disappear while the hypnotic state lasts. The authors call this method of hypnotic treatment "cathartic," and illustrate their theory by various clinical cases.

Abnormal Sleep and Epilepsy.

In his article on "Pathologische Schlafzustände und deren Beziehung zur Narkolepsie," Dr. Schultze relates two cases which render it probable that abnormal sleep is of the nature of epilepsy. Of the success of Flechsig's treatment of epilepsy (by Opium-Bromkur), Dr. Linke gives an account, and says that success is attained in a shorter time than by other methods, although prolonged observation is necessary before an absolute opinion can be stated. Drs. Rabbas and Wulff are of the same mind.

Imperative Ideas.

Dr. Thomsen agrees with Westphal in regard to imperative ideas constituting an idiopathic mental disease, thus differing from Magnan, who looks upon them as phenomena of degeneration. This disease presents mental and bodily symptoms. The former comprise ideas and sensations of compulsion, compulsory processes of a motor kind, tic convulsif; the latter comprise digestive and circulatory disorders, habitual headache, etc. The prognosis is bad, for suicides are common in such cases.

Delirium of Typhoid Fever.

Dr. Aschaffenburg has made a careful study of the delirium of typhoid fever, which he finds to be of a hypochondriacal or maniacal nature, although the former is often followed by the latter in the same case. Sometimes the mental symptoms exist before the fever declares itself, and there is no correspondence between the degree of the fever and the mental phenomena. They may even alternate. In three cases automatic movements and verbigeration were recorded. A lucid interval is often followed by delirium or stupor. Dr. Aschaffenburg holds that the delirium is the result of toxic qualities affecting the cortical cells, as Nissl has recorded in one case. He gives a bad prognosis in such cases.

Quäculantenwahn.

This form of paranoia has lately been studied and reported upon by Drs. Gerlach and Aschaffenburg. The former is of opinion that the morbid disposition to lawsuits is a question for the law courts; the physician has to determine if the person is insane. Although these cases are usually paranoiacs or imbeciles, and have a substratum of right in their actions at law, there is another class who are neither paranoiacs nor imbeciles, and it is necessary that the pathological basis of their malady should be set forth—that the dominant idea is irresistible. Dr. Aschaffenburg is of opinion that the question of legal right is not conclusive, for the quarrelsomeness continues after a verdict satisfactory to the abnormal individual. Dr. Hitzig, on the other hand, considers this malady to be only a species of paranoia. Dr. Koeppen advises that this name (*Quäculantenwahn*) should be avoided in courts of law, because quarrelling is common to sane and insane. The evidence of mental aberration must be sought in the existence of other symptoms of insanity, and their origin must be explained. The temporary disappearance of the symptoms is a noteworthy fact.

Reforms in Lunacy Administration.

The reforms demanded in Germany were stated by Drs. Siemens and Zinn at the annual meeting of the Verein der Deutschen Irrenärzte in September last. They urge that a knowledge of psychiatry should be made compulsory in the State examinations; that the proportion of doctors in asylums should not be less than one to each hundred patients; that attendants should be more numerous and their pay improved; that the direction of pauper asylums for idiots and imbeciles should not be left to the clergy. They are of opinion that the insane criminals should not be left in ordinary asylums, and regard it as a calumny that statements should be made to the effect that sane persons are confined in such asylums. They demand that a Special Committee of the Ministry should be formed, and that one member of that Committee should be a physician experienced in lunacy administration.

Psychical Paralysis.

Dr. Freund has written an article defending the thesis that hysterical paralyses are psychical paralyses, but that every psychical paralysis is not hysterical. He distinguishes localised cerebral paralysis from psychical paralysis in that the former is the result of a lesion of the association fibres anatomically connected in a circumscribed area, while the latter is the result of damage to the fibres associated by experience and by perceptions. The fibres of association physiologically connected may belong to parts of the brain anatomically remote from one another, and cannot, therefore, be injured by a circumscribed lesion, but by an

abnormal distribution of the nervous tension in their track. Pathologically diminished tension in these fibres produces paralysis, anæsthesia, amnesia, etc.; increased tension produces contractures, hyperæsthesia, etc.

Developmental General Paralysis.

Dr. Bresler reports a case in a girl aged 13, in whom he observed a symptom which he has named crossed alternate deviation of the head and eyeballs. During the convulsions the head was turned towards the left, the eyeballs towards the right, and *vice versa*. Chorea had occurred before the onset of the general paralysis, as in a case reported by Dr. Middlemass. Dr. Bresler considers this disease more frequent among girls than boys.

HOLLAND : By Dr. COWAN.

In Holland psychological medicine is beginning to be recognised as an indispensable part of the education of a physician. It is strange that, in the country in which Schroeder van der Kolk lived and taught, the authorities should have been so slow in creating a chair for mental diseases. Dr. Winkler was appointed a lecturer in the University of Utrecht in 1885, and has since been appointed professor in psychiatry and neurology. Steps have been taken to place the professor in possession of a suitable clinic.

The Medico-Psychological Association of Holland has been indefatigable in urging this as an absolute necessity upon the Government, and it may justly be satisfied to see its dearest wish realised, even though this is only part of what was required. Mental medicine, as well as surgery, midwifery, etc., should form part of the programme of lectures at every university.

Besides at Utrecht, psychological medicine is taught at Amsterdam. Dr. van Deventer, while physician-in-chief to the suburban hospital at Amsterdam, lectured on mental diseases, and so utilised the great number of insane patients annually passing through that establishment. After his appointment as Medical Superintendent of the Meerenberg Asylum, Dr. van Deventer continued his lectures there. A great drawback is that students have to travel about forty minutes by rail to attend these lectures.

The Universities of Leyden and Groningen still afford no opportunities for the study of mental medicine; but asylums are being built in the neighbourhood of these towns, so that we may expect that this want will soon be remedied.

Another subject in which the Association takes a warm interest is the training of nurses and attendants. Several asylum physicians feeling the necessity of having a properly trained staff of attendants have already begun series of lectures in nursing. In most cases the Boards of Governors warmly supported the physicians; but in one asylum in the province of South Holland

(Dordrecht) the Board of Governors forbade such teaching. The fact seems almost incredible, yet it is quite true. One of the arguments given was that the application of a roller constituted an experiment made on patients!

The Medico-Psychological Association have appointed an Examining Board, and grant a diploma for efficiency. The measure has worked well, and several diplomas have already been gained by successful candidates. The questions put relate to nursing, hygiene, emergencies, etc. In order to be admitted to the examination it is necessary to produce a certificate of good conduct and to show that three years have been passed in asylum work. It is often difficult to instruct those whose preliminary education has been slight, and the Medical Superintendent of the asylum at Medemblik (Dr. Breuning) has added a course of ordinary schooling to his nursing lectures.

It is a pity that the pay for nurses is still small, so that several, and in most cases the best of them, endeavour to find a more profitable livelihood. The measure of demanding a course of service of three years as indispensable was adopted in hopes of inducing attendants to stay longer than they did. As far as we can judge, the system works well.

A strife which in some asylums is still waged hot and fierce, is the position which the chief physician is to occupy. In most of our asylums the principle is being recognised that the physician-in-chief must be the Superintendent in the fullest sense of the word, while the Governors are the controllers of the expenses. But in a few quite a different view is taken, and the Governors try to make the physician the humble executor of what they think the proper course. Conflicts often arise in consequence, and in some cases these are carried on to the disadvantage of the patients. Thus, for instance, in one asylum (Dordrecht) four single rooms were built against the express advice of the physician, who condemned the plans as bad and fraught with danger to such patients as might be placed in them. The result was that two patients had their backs very badly scorched; and even then the stony-headed architect could not see that his plans were at fault. Nay, more, this same builder of crematories, Mr. van den Steenhoven, thought he had found a way of squeezing sixty patients into a small airing-court. Even the argument that this plan would only give each patient about two metres superficial space could not convince him that he was wrong, and that his plan had best be put into the waste-paper basket.

It will be remembered that our present law was passed in 1884, and that it was then received with very different opinions. While some physicians remarked that the law gave the judicial authorities too great an influence in asylum matters, others thought that the law did not go far enough. Exactly as in England, the majority look upon asylums with some distrust, and occasionally this dis-

trust finds vent in angry articles in the newspapers when it is thought that unlawful things have happened. Two such cases recently occurred in Holland.

One of the cases was a physician who, by dint of industry, had earned a small competence. From time to time his teeth felt loose and raised, the secretion of saliva increased, and he suffered from intense perspiration. The consequence was that he believed that he was being poisoned by pilocarpine. Conviction was child to suspicion, and he soon began to say his wife gave him the poison, or rather that she rubbed his linen with it, and that it penetrated his skin. The man was sent to an asylum, but was dismissed by order of the tribunal, who considered that he was not insane. During his stay of thirteen months he had most admirably concealed his delusions from most people, but no sooner was he discharged than he wrote a most interesting book—the autobiography of a lunatic physician. He inveighs against the asylum authorities, his friends who joined in the plot to keep him in prison, as he styled it, who refused to rescue him, and so on.

The other case was that of a lady suffering from delusional insanity, who wrote a pamphlet full of accusations against the medical and the nursing staff of the asylum of which she was an inmate. This at least had the good effect of turning the public attention to the misrule of the Governors and their minion the steward, who were obliged to resign.

In both cases there were fierce articles in the newspapers, and asylums in general were very unjustly criticised.

As I mentioned our present law has been in force since 1884, and its merits and demerits have been discovered in practice, and reform has been called for from several quarters.

In the first place it is urged that admission into an asylum should be simplified. The formalities to be gone through, easy though they may be, still deter many people. The physician in charge of the case certifies the insanity of the patient; this certificate is registered, and then laid before a Justice of the Peace, who either orders another medical examination, or (as is almost always the case) authorises the relatives to place the patient under asylum treatment. In urgent cases the burgomaster may give the authorisation. Why, it is asked, should all this fuss be necessary? Why cannot insane people be admitted into an asylum in the same way as ordinary patients are admitted into an hospital? Let inspections continue as at present; frame every safeguard to make illegal detention impossible; but do not lose precious time as at present. It is gratifying to see that the Inspectors in their last report to the Minister of the Interior point out the necessity of simplifying the formalities.

It was considered an improvement in our present law that lunatics who were not inmates of asylums should have the benefit of State inspections. Asylum inmates were seen by different

officials, while those who needed supervision most, *i.e.*, those living with private persons, were left entirely unprotected against ill-treatment. This new duty of the Inspectors has been the cause of very conflicting opinions. Do not the Inspectors overshoot the mark by inspecting these out-patients too often? Is it not sufficient to visit only those dwellings where it may be thought that the insane boarder is not properly treated, whilst others might be left at rest?

The following curious instance once occurred to me. A lady, subject to delusions of grandeur and hallucinations, was treated in her own house, and, consequently, was not subject to inspections. The husband asked my opinion about a stay of two or three months during summer at the Hague. The sister-in-law had invited her, and the patient was very desirous to go. When, however, I told him that his wife would be subject to State inspection if she stayed with her sister-in-law, the husband refused to let his wife go, as he would not allow Inspectors to meddle with what he considered no business of theirs.

Another difficulty arises when there is a difference in diagnosis. A definition of insanity cannot be given; in fact, what Dr. Johnson said about defining poetry is applicable to insanity, *viz.*, that all such attempts will only show the narrowness of the definer.

When the present law omitted all definitions every physician thought this an improvement. But never was a definition more wanted. When a physician has a patient under his care and makes the diagnosis of hysteria, and the Government officials call it a case of insanity, by what standard are they to gauge their diagnosis? and who is to give the verdict? Such cases have happened.

The present law brought us a most welcome clause relating to leave of absence for asylum inmates. There were no similar regulations in the former law, and it was warmly stated that such an important point had at last been properly considered. The article says that, with the consent of the relative who applied for the admission, the physician in charge is authorised to allow such patients as he think fit to leave the asylum for a certain time—in fact discharge on trial. It is often used and considered an excellent way of testing a patient's recovery, and therefore often precedes a final discharge. What the Legislature did not think of stipulating was how the matter was to be arranged if it was thought beneficial to the patient, in face of the refusal of the family.

In one of the asylums with which the Province of Zealand had arranged for the accommodation of its insane, the Chairman of Governors, with obdurate stupidity, forbade the article to be applied to Zealanders because the provincial authorities refused to pay the full price for such people as were not regular inmates. Thus a highly beneficial measure may be paralysed by the imbecile views of one or two ignorant men. Such an asylum is worked on the sweating system, and not to benefit the insane.

It is gratifying to notice that the alienist's advice in matters of criminal justice is often taken by our judges. It is absurd that the reason why A. should be in an asylum while B. should be a prisoner is simply this: that A.'s career was crossed by a physician, while B.'s was stopped by a jurist. The expert's position is a very delicate and difficult one, and our alienists must be careful to maintain the position they are slowly obtaining.

In their last three-yearly report the Inspectors give an interesting account of their work in prisons. The fact that so many prisoners were found to be insane makes it desirable that this inspection, first introduced in 1891, should form a part of the regular routine. The report tells us that 52 prisoners were insane in 1891, 48 in 1892, and 33 in 1893.

Restraint has been almost entirely abolished in Dutch Asylums, and the far more humane way of treatment in bed is finding great favour with our medical men.

ITALY: By Professor BIANCHI.

BIANCHI, L.—*Lezioni cliniche sulla Frenosi sensoria (Clinical Lectures upon Psychoses originating in Sensory Disturbances)*. Naples, 1895.

Clinical observation demonstrates the existence of certain forms of mental disorder represented originally and, in some cases, for a greater or less period, exclusively, by sensory disturbances, upon which, however, various affective and intellectual disorders may supervene. Prof. Bianchi shows how these forms, hitherto badly defined, or confused with other morbid conditions totally distinct, are simply varieties of *Frenosi sensoria* (as above defined), which is to be regarded as a clinical entity. Classifying these varieties, a group is formed comprising certain cases, not very frequent, for which Prof. Bianchi proposes the name of *Frenosi illusionale e percettiva*, since the psychosis is originated by a false perception, which, in the result, produces profound disturbance of the mind, with alteration of character. A second group—the most important—comprises cases in which a vivid hallucination “surprises” the mind, up to that moment functioning normally, and thereupon ensues a psychopathic state, characterised by delirium, or stupor, or melancholia, or a disturbance of the mental tone which may pass into an actual systematised delusional insanity. Many cases of paranoia originate in this way, and therefore should be regarded as secondary paranoia of “sensory” origin, and distinct from primary paranoia of “intellectual” origin. Similarly, mental confusion, in the majority of instances, is merely a secondary phenomenon of *Frenosi sensoria*. Prof. Bianchi, however, recognises the existence of a primary confusional state, but holds that this form is extremely rare, as compared with the other. Taking

as his basis the most recent views upon cerebral histology and physiology, the author studies the mode of production of the most important phenomena of this psychosis of sensory origin, and the causal relations existing between them. A third group is comprised of individuals who experience various hallucinations, not very intense, but which may be repeated over a very long period, without disturbing the mind.

COLELLA, R.—*La psicosi polineuritica (Psychosis Polineuritica). (Annali di Neurologia.)*

This malady, already described by Korsakoff, has recently been reinvestigated and exhaustively treated by Colella. The disease, in the causation of which toxic agents (especially alcohol), or infective, always figure, is characterised by the association of a particular psychical alteration with the phenomena of multiple neuritis (amyotrophic paralysis, disturbances of sensation, etc.) Amnesia is the predominant psychical symptom, and with this are associated, in various degrees, disorders of consciousness and of the association of ideas, and, not infrequently, agitation and delirium. The amnesia has the following characters:—(a) it is sometimes almost instantaneous, embracing all recollections, limited to acts and recent impressions; (b) ordinarily it is temporary, interposed between two periods of normal memory, and confined to recent facts, alike antecedent and subsequent to the appearance of the malady; (c) it is isolated, sometimes independent of any other intellectual disturbance, and characterised by the loss of the faculty of evoking reminiscences.

COLUCCI, C.—*Sulla cosiddetta retinite dei paralitici (On the so-called Retinitis of Paralytics). (Annali di Neurologia.)*

Colucci finds from the histological examination of the retina in eleven paralytics that the process may develop in three different ways:—1st. Primary atrophy of the nerve—and neuroglia—elements, independent of vascular implication. This is the most frequent form, and furnishes the greatest irregularities in respect of localisation of the disease. 2ndly. The prevalent disorder is in the vessels, in the form of extraordinary fibrillar and nuclear proliferation of their walls, especially where syphilis has been contracted. 3rdly. Retinal atrophy is secondary to the degeneration and destruction of the higher visual centres. The evolution of the disease is in this form slow and regular.

BIANCHI, L., AND PICCININO, F.—*Nuovo contributo alla dottrina della origine infettiva del delirio acuto (A Contribution to the Doctrine of the Infective Origin of Acute Delirium). (Annali di Neurologia.)*

The authors describe a case of acute delirium in which bacteriological examination of the blood showed the bacillus already described by them in a previous publication. Researches conducted after the same method in certain cases presenting a symptom-

complex nearly allied to that of acute delirium, and in certain others of acute stupor, led to negative results, as regards the presence of the bacillus met with in acute delirium, but demonstrated the existence in these cases of certain micro-organisms (*streptococcus pyogenes*, *staphylococcus aureus*), and, further, of a certain relationship between the clinical condition and the presence of these organisms in the blood, in that the latter diminished in number and disappeared with the decline of the disorder. A comparative study of these cases and those previously recorded shows that amongst the psychopathic states bearing the character of acute delirium there is one to which the name "Acute Delirium of Bacillary Origin" may be assigned. This is distinguished from all the others, clinically, by the greater intensity of the various symptoms, by the adynamic state, which rapidly follows upon that of excitement, by the much shorter course, and by the fatal termination; and bacteriologically, by the presence in the blood and nervous centres of the particular bacillus isolated and described by the authors.

PICCINIUS, F.—*Ricerche batterioscopiche sulla corteccia cerebrale di individui morti con paralisi generale progressiva* (*Bacterioscopic Researches upon the Cerebral Cortex of Fatal Cases of General Paralysis of the Insane*). (*Annali di Neurologia*.)

These investigations were carried out on the brains of five paralytics. The author describes the methods adopted, and an important observation made by the use of a method much resembling that of Lustgarten. He raises the question whether the numerous bacilli demonstrated by this method are simply identical with the organism which Lustgarten regards as the causative agent in syphilis, or whether they are a specific agent in the causation of general paralysis. It is to be noted that syphilis was clearly established in the history in three of these cases, although not in the remainder.

VENTURI, S.—*Rapporti fra cervello, testicoli, ed ovare nelle pazzie involutive* (*Relationship between Brain, Testicles, and Ovaries in Degenerative Psychoses*). (*Arch. di Psichiatria*.)

The author records fourteen observations upon men, dead of general paralysis in middle life, which go to show that the average weight of the brain of paralytics is gr. 1090, and that of the testicles gr. 9.80; whereas the average weight in health is, for the brain gr. 1410, and for the testicles gr. 18. This points to the conclusion that "in the insane the diminution of weight of the brain, due to premature atrophic processes, finds an almost exact parallel in the diminution of the weight of the testicles." This diminution of the weight of the testicles in demented being accompanied almost always by diminution in volume and consistence, the author concludes that "herein we have during life an approximate criterion, serviceable in assisting us to diagnose cerebral atrophy, and also,

to a certain point, in estimating its degree." The relationship between the diminutions in weight of the brain and the ovaries would seem to be less evident, at least, as far as the author has been able to infer from observations in nine women, seven dead of consecutive dementia, and two of general paralysis.

MIRTO, G.—*L'eccitabilità elettrica dei nervi e dei muscoli degli idioti*
(*The Electric Excitability of the Nerves and Muscles in Idiots*).
(*Riv. sperim. di Freniatria*.)

These researches were carried out upon sixteen typical idiots. The following nerves were examined with the electric current: facial, ulnar, median, tibial, peroneal; and the following muscles: frontal, biceps, common extensor of the fingers, vastus internus, peroneus longus. In addition, the electric sensibility over the temples and in other regions of the body was examined. The results showed that the neuro-muscular excitability in idiots may be notably diminished; but this is not a general law. Moreover, in the same individual considerable differences are to be met with between the various nerves and muscles. None of the subjects showed qualitative disturbances in the electrical reaction. In many analgesia was noted, alike with galvanic and faradic currents. In one case which came to an autopsy the author found deficiency of the myeline sheath in the peripheral nerve fibres; and he is disposed to think that the diminution of electric excitability, and even to a certain point the analgesia, is referable to this defect.

PIANETTA, C.—*Contributo allo studio dei tumori dei lobi frontali*
(*Contribution to the Study of Tumours of the Frontal Lobes*).
(*Riv. sperim. di Freniatria*.)

The author relates the case of a girl, aged 21 years, presenting the following conditions: Complete amaurosis, choked discs, ptosis, rigidity of pupils, impairment of olfactory sensibility, headache, stupidity, yawning, vomiting, general catatonic state. Death ensued, and at the autopsy a tumour was found "in the frontal region, in a situation corresponding with the fissure between the hemispheres, and in its basilar portion," which tumour extended laterally into the frontal lobes, indenting and implicating especially the orbital area, and posteriorly as far as the anterior perforated spot, compressing and crushing the chiasma, and compressing likewise the corpus callosum, which was pushed backwards. The neoplasm was firmly adherent to the brain tissue, and it destroyed almost wholly the frontal portion of the gyrus of the corpus callosum on both sides.

LUI, A.—*Sopra alcuni recenti trattamenti della epilessia* (*On Certain Recent Methods of Treating Epilepsy*). (*Riv. sperim. di Freniatria*.)

Having thoroughly tried the method of Flechsig (opium and bromide) in three cases, and that of Bechterew in ten cases, the

author concludes that both methods are capable of yielding good results; the former is perhaps of greater efficiency in respect of the convulsive attack and of occasional psychical disturbances, whereas the second has the advantage of being much more readily tolerated by the organism.

GUICCIARDO, G.—*Il liquido di Bechterew nella cura dell' accesso epilettico* (The Use of Bechterew's Fluid in the Treatment of the Epileptic Convulsion). (*Riv. sperim. di Freniatria.*)

The author has employed this fluid mixture in four classical cases of epilepsy for six continuous months. The results lead to the conclusion that this fluid does not cure the disease. It influences the epileptic attack by virtue of the amount of bromide which it contains; in general it is well tolerated, and can be administered for a long period without harm. In conclusion, it acts, and may be employed, like simple bromide for subduing the violence and the frequency of the convulsive attacks, and may be used in preference when it is necessary to take into account the cardiac vigour and the general condition of debility.

GUENIERI, R.—*Sul peso del cranio e della mandibola nei normali, nei pazzi, e nei delinquenti* (On the Weight of the Cranium and Lower Jaw in Normal Persons, in the Insane, and in Criminals.) (*Archiv. di Psichiatria, etc.*)

From a comparison made between the weight of the cranium and of the lower jaw in 75 male skulls (25 normal, 25 of insane persons, 25 of criminals), it appears (1) that the weight of the normal cranium is below that of the insane, and the latter, again, below that of the criminal; (2) that the same rule applies even more markedly in the case of the lower jaw.

D'ABUNDO, G.—*Le impronte digitali in 140 criminali* (The Digital Impressions in 140 Criminals). (*Archiv. di Psichiatria, etc.*)

The author's studies show that asymmetries, anomalies of the *torus tactus digitalis*, and cicatrices are frequent in criminals. The anomalies indicated were met with with much greater frequency than in the insane. The author assigns considerable importance to cicatrices, which impart a distinctive character. He advises that in future digital impressions should not be neglected in noting anthropological characteristics of delinquents, as they are capable of playing an important practical part in the task of identifying an individual.

DE SANCTIS, S.—*Ricerche anatomiche sul nucleus funiculi teretis* (Anatomical Researches upon the Nucleus of the Funiculus Teres). (*Riv. sperim. di Freniatria.*)

Having regard to the paucity of information and the opposition of views upon the anatomical relationships of this nucleus in

different mammals, the author undertook a series of researches upon the point in adults, in new-born infants, and in animals (apes and dogs). The observations hitherto made do not permit him to draw formal conclusions concerning the relationships of the nucleus of the funiculus teres to the nuclei of the ninth, tenth, and eighth nerves, and to the superficial internal arciform fibres, to the striæ acousticae, and the funiculi teretes of the rhomboidal fossa. They, however, show with sufficient clearness the independence of the nucleus of the funiculus teres from the nuclei of the sixth and twelfth nerves. From the same observations it follows that the distal portion of the nucleus of the funiculus teres, whilst it is found to be completely developed in the adult, is not met with in the new-born, in apes, and in dogs; from which it is to be gathered that this nucleus, morphologically, should be regarded as consisting of two portions, of which the proximal, ontogenetically and philogenetically, has a higher significance than the distal.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

GENERAL MEETING.

A General Meeting of the Association was held in the Pathological Laboratory, New Museums, Cambridge, on Thursday, February 20th, Dr. David Nicolson, President, in the chair.

Dr. FLETCHER BEACH, Honorary General Secretary, read the minutes of the last General Meeting, and they were confirmed.

The following gentlemen were elected as members of the Association:—Arthur Norman Boycott, M.D.Lond., M.R.C.S.Eng., L.R.C.P.Lond., Assistant Medical Officer, London County Asylum, Cane Hill, Purley, Surrey; Matthew William Stuart Isacke, M.R.C.S.Eng., L.R.C.P.Lond., Assistant Medical Officer, West Riding Asylum, Wadsley, Sheffield; John Maclaren, M.B., C.M.Edin., Assistant Medical Officer, West Riding Asylum, Wadsley, Sheffield; Charles Planck, M.R.C.S.Eng., L.R.C.P.Lond., M.A.Camb., Assistant Medical Officer, East Sussex County Asylum, Haywards Heath; Matthew Burrow Ray, M.B., C.M.Edin., Pathologist and Assistant Medical Officer, West Riding Asylum, Wadsley, Sheffield.

Dr. RAYNER—I think we should not enter upon the business of the meeting without an expression of our feeling with regard to the promotion which has lately come to our President. (Applause.) I am sure that we not only rejoice in it because of our good feeling towards him, but because it is an honour to the Association, and we are all very glad indeed that it has happened during the time of his presidency of the Association. I am sure you will vote with acclamation our expression of congratulation to the President on his promotion. (Applause.)

The PRESIDENT—This unexpected expression of goodwill towards me is one that touches me very much. After a lengthened service I have been fortunate enough to land amidst more easy surroundings than I have had during the twenty-nine years in which I have been engaged on work such as the Association devotes itself to. No little part of my success was due to the great fortune I had to be President of this Association, because it was an indication that I was trusted by those with whom I had been associated for so many years. I cannot let this opportunity slip without saying that I believe the Association has in the past done

good work, and that there is a great work in store for it in the future. I am sure that no words of mine will express to you the kindness of feeling that I have had expressed to me by so many old friends and by so many members of the Association who have taken an active part with me in the work of the Association. I can only express my great gratitude to those who kindly offered me congratulations on the appointment which has fallen to my lot, and to say that in carrying out my work it will be my earnest endeavour to do so honestly and consistently, and with due consideration not only for those who are placed in the responsible position of looking after those unfortunate persons whose minds wandered from the normal standard, but also in the interests of those unfortunate persons themselves. If by any error of judgment I should seem to fail, it will simply be an error of judgment. I thank you once more for your kind words. (Applause.)

DR. LOCKHART ROBERTSON'S GIFT TO THE ASSOCIATION.

Before asking Dr. Rivers to address us, may I take the opportunity of saying that at the Council Meeting a letter was read from my predecessor in office, Dr. Lockhart Robertson, asking the Council to accept a number of books in reference to insanity and its treatment that he had collected during the course of a number of years. The books will be a valuable addition to our library, which will be of the greatest service to us all. Dr. Lockhart Robertson's example will be one for us all to follow when we have an opportunity of giving up our books for the use of those who are in more active work than perhaps we ourselves may be later on. I think I may ask the Association to corroborate the expression which is to be sent by the Council to Dr. Lockhart Robertson—an expression of our best thanks for his kind and generous gift. (Applause.)

Dr. BOURNVILLE FOX—May I ask whether the titles of the books will be published in the *Journal*?

The PRESIDENT—That will be a question for the Library Committee. That Committee is very much *en evidence* just now. They are going to have all the books catalogued, and members will then have an opportunity of giving what instructions may seem good to them.

PAPERS READ.

Dr. RIVERS then made a communication upon "Laboratory Observations on Mental Fatigue and Recovery." This, with the discussion, will appear in the next number of the *Journal*.

Dr. HYSLOP read a paper on "Pseudo-General Paralysis of the Insane." This is published at page 303 of this number of the *Journal*, but the discussion was adjourned till the next General Meeting, in the report of which the whole debate will appear.

Dr. FLETCHER BEACH read "Notes of a Case of Tumour of the Brain," which will be published in the next number of the *Journal*, together with the illustrations prepared by the author.

In closing the meeting, the PRESIDENT said that the members of the Association must feel grateful to the University authorities for having provided such excellent accommodation for the meeting, and for having welcomed them to Cambridge. He concluded by moving a vote of thanks to the Curator of the Museum for so kindly placing their rooms at the disposal of the Association. (Applause.)

MEDICO-LEGAL CASES.

REPORTED BY DR. MERCIER.

[The Editors request that Members will oblige by sending full newspaper reports of all cases of interest as published by the local press at the time of the Assizes.]

Reg. v. Wright.—"The Mansfield Murders."

Henry Wright, 35, labourer, was indicted for the murder of M. E. Reynolds, C. Reynolds, W. H. Reynolds, and Wm. Peck, at Mansfield, on August 11. The prisoner failed to plead to the indictment, and the Judge remarked that to his mind the prisoner at first sight presented symptoms of insanity, and his lordship further

suggested that a jury should be sworn to try whether the prisoner was capable of pleading. This was done, and

Captain Smail, Governor of the Gaol in which prisoner had been detained for nearly four months, deposed that he asked the prisoner if he understood the value of the charge brought against him, and that prisoner did not seem to grasp it. A warder was asked, "Have you told prisoner to do anything, and did he seem to understand?" A.: "Not in particular." Prisoner understood when told to make his bed, and obeyed orders.

Dr. H. O. Taylor, Medical Officer of the Prison, thought that prisoner was capable of understanding such a question as to whether he is to plead guilty or not.—Has he seemed to understand when you have spoken to him of the crime?—Not completely.—The Judge: What do you mean? One would think that if he understood partially he would understand completely.—I think as to the time of committing the crime his mind is absolutely blank, and therefore when I have conversed with him upon that part of it he had no knowledge whatever. In answer to further questions the witness was of opinion that the prisoner knew that he was going to be tried, and understood when asked whether he was guilty or not guilty. The jury, after some hesitation, found that the prisoner was fit to plead, and the trial proceeded.

The prisoner lodged with Elizabeth Reynolds, and in the same house at the time were George Reynolds, her stepson, W. H. and C. Reynolds, her sons, and two grandchildren. The prisoner went home at a little after midnight on the night of the murder. At two o'clock in the morning he went to the police station in the following condition: He was quite naked, except his socks; his throat was cut; in his arms was a child—one of the grandchildren of Mrs. Reynolds—whose nightdress was on fire. He went into the police station, threw his arms about, threw himself on to the floor, tried to speak, but on account of the wound in his throat could not be understood. Subsequently (after a doctor had been sent for and had arrived) he made the following statement: "I have murdered four. I have killed the landlady, Charlie, Willie, and little Willie, and I have set fire to the house." After an interval he said, "It is through jealousy; if I could not have her no one else should. I killed the landlady and three children and set the house on fire." When the house was searched, it was found to be on fire in two places. The body of the woman was found horribly mutilated. The breasts had been cut off. The thighs were cut open down to the knees. The body was disembowelled, and the sides of the abdomen stretched apart by means of a stair rod placed across. The dead bodies of the children were found, and it was found that the door of the room in which the stepson slept had been fastened on the outside, so that the latter could not get out.

It was proved that in the previous April the prisoner had had a fit, and a second fit about six weeks after.

Dr. G. P. Godfrey, police surgeon, stated that he saw the prisoner at the police station at two o'clock on the morning of the murder. He examined the prisoner specially as to whether he was drunk or sober, and the prisoner was perfectly sober. Subsequently, when being committed by the magistrates, prisoner pretended to have an epileptic fit. When Dr. Godfrey slapped his face and touched his conjunctiva prisoner said, "Sooner than go through this treatment I will go back and hear the evidence." This witness was not asked as to the sanity of the prisoner.

Dr. P. L. Robinson, who had the prisoner under his charge in the workhouse infirmary, deposed that while in the infirmary the prisoner shammed epilepsy on more than one occasion. Witness stated that epilepsy was closely associated with insanity, and answered one or two questions about homicidal mania.

For the defence Dr. Owen Taylor, surgeon to the gaol, said that while in prison prisoner had several fits, whose genuineness Dr. Taylor had no reason to doubt. Witness was examined as to homicidal mania, and stated that a person suffering from this malady would commit murder without a cause being apparent, and often with circumstances of great atrocity. The attack might be very brief. In his opinion the prisoner was of sound mind at the present time (of trial).

Dr. Nicolson, of Broadmoor, deposed that he had examined the prisoner, and had no reason to think at any time that he was insane. "The impression I have formed was that at the time of committing these acts his mind was in a condition induced by an excessive indulgence in alcohol."—Do you consider at the time of committing these acts he knew what he was doing?—I do not. He was drunk, and suffering from the after effects of drink.—After effects in what form?—That deprived him of the power of consistently knowing what he was doing.

Dr. Powell, Superintendent of the Borough Asylum, had examined the prisoner, and came to the conclusion that he was a weak-minded man, considerably confused in his mind, and very depressed. Witness was asked about homicidal mania, which he stated was a well-known form of insanity, in which it was very often the case that the patient took life without any apparent motive, and in which the crime might be accompanied by great atrocity.

The Judge told the jury that the facts being proved, the prisoner was *prima facie* guilty unless he satisfied them that he was insane at the time—that he was so deprived of the use of his reason by disease of mind as not to know the nature and quality of the act he was doing. The suggestion was made that the offence itself was so atrocious that the man must have been mad, but there was no such inference in law or in common sense. The next suggestion was that the prisoner had epilepsy, and that epilepsy was akin to insanity. Epilepsy in some remote sense might be deemed akin to insanity, but epilepsy and insanity, he thought he might say, were, in the medical sense, as far as the poles asunder. Epilepsy weakened the brain, no doubt, and people who had frequent, constant epileptic fits became enfeebled in intellect. The witnesses who knew Wright well had not been asked a single question as to whether he had suffered from epilepsy during the years they knew him.

The jury, after a deliberation of twenty minutes, found the prisoner guilty.—Nottingham Assizes, December 4, 1895 (Mr. Justice Day).—"Nottingham Daily Express," December 5, 1895.

The Judge was so struck with the demeanour of the prisoner in the dock that he ordered the issue to be tried whether the prisoner was of sufficiently sound mind to plead to the indictment, and it was only after some hesitation, and after assistance from the Judge, that the jury found him fit to plead. Yet at his trial the plea of insanity failed. The case is, therefore, one in which it appears *prima facie* as if an insane person had been wrongfully convicted. It is necessary, therefore, to examine the evidence with care.

The prisoner, after murdering the woman and three children, and cutting his own throat, took a fourth child in his arms and carried it to the police station. The child's night dress was on fire, but the prisoner seems to have made no attempt to put it out, and he himself was naked with the exception of his socks. Such conduct, taken together with the apparent absence of sufficient motive for such a very barbarous crime, raises a suspicion of insanity in the agent, a suspicion that is so strengthened by the demeanour of the prisoner in the dock that the Judge directs the issue to be tried whether the prisoner is fit to plead. We have to inquire—(1) Why the plea of insanity failed; (2) Whether the plea ought to have been established; (3) How far the failure of the plea was due to the law as stated by the Judge. It is evident that the third question is included in the first, but it is advisable to lay special stress upon it.

The evidence in favour of the insanity may be summarised thus:—

1. The atrocity and circumstances of the crime.
2. The inadequacy of motive.
3. The history of epilepsy.
4. The medical evidence.

The crime was, as has been described, one of revolting barbarity. Four persons were murdered, and one was in addition horribly mutilated. Is extreme atrocity in a crime sufficient of itself to establish the insanity of the criminal? To this question there can be but one answer, that of the Judge, who told the jury that no such inference in law arose, and there was no such inference in common sense. It is matter of common knowledge that when the rein is given to passion,

whether bloodthirstiness or lust - and in this case there were probably both—the appetite grows with its indulgence, and, in his gathering frenzy, the agent plunges into excesses which he had at first never contemplated, and at which he afterwards stands appalled. Mad he may be in one sense—in the sense in which the maxim *ira furor brevis est* is to be understood—but if such an access of frenzy is to be held an excuse for crime, we may as well abolish our criminal jurisprudence alto ether, or reserve it for minor offences only.

There was more than mere atrocity in the circumstances of this crime, however. After it was over the murderer went to the police station with one of the children, the one that he did not murder, in his arms. His own throat was severely cut; the child's nightdress was on fire. He himself was absolutely naked except his socks. These circumstances he ignored in his determination to carry out his intention of giving himself up to the police. Such action is, undoubtedly, upon the face of it, highly suspicious of insanity. Ought it to have so weighed with the jury as to establish in their minds the conclusion that the prisoner was at the time of the crime so insane as to be irresponsible for his acts? If they had so regarded it, is it not obvious that they would have been proclaiming to future criminals a method of obtaining impunity, by doing some eccentric act immediately after the crime?

2. As to the inadequacy of the motive for the crime, we must take the prisoner's own account of his motive. He had desired the woman for years, and after the deed he said "It's through jealousy. If I could not have her no one else should." It will be admitted that if he had simply cut the woman's throat, the motive that he alleged would, according to common experience, have been an adequate motive for the commission of such a crime by a man of low and somewhat brutal nature; and that the question of insanity would not have arisen. Does the fact that in addition to cutting her throat he disembowelled and otherwise mutilated her, remove the act outside of the possibility of the reaction to the motive of jealousy of the sane mind of a man of his class, antecedents and surroundings? This question cannot be answered in the affirmative. (The onus of proving insanity is, it must be remembered, upon the prisoner. The presumption is that he is sane. If there is a doubt as to the fact that he committed the murder, he is entitled to the benefit of the doubt. But if there is a doubt about his insanity he must be convicted. To be found "guilty but insane" the insanity of the prisoner must be not probable, but proved beyond doubt.) To the ordinary or average man the motive of jealousy is not enough to prompt to the comparatively trivial act of murdering the woman of whom he is jealous. Yet in some men this motive does prompt to this action, and by universal consent the action is considered as sane and as sufficiently accounted for by the motive.

A certain excess of action, beyond what the motive prompts in ordinary minds, is therefore universally regarded as consistent with sanity. Is a greater excess to be regarded as inconsistent with sanity? and, if so, how much greater must the excess be before we can presume insanity in the actor? Is there any point at which the excess of reaction to motive becomes of itself proof of insanity? We cannot say that there is. No doubt a great excess of reaction raises a *suspicion* of insanity—it did so in the case under consideration. But suspicion is not proof—it is not even presumption. It can only afford a guide as to the direction which the defence is to take.

But supposing that our conclusion is wrong, and that there is a point at which the excess of reaction to motive does raise a presumption, or even is in itself proof of insanity, how and by whom is this point to be determined? Are medical experts prepared with a formula to fix the point? Scarcely. And if they are, has their formula any chance of acceptance? Again, scarcely. Who then is to decide the point? Clearly the jury. It is eminently a question for the jury to determine. In this case, the jury, having before them the evidence of fact and the expert evidence of opinion, answered the question in the negative. The argument in favour of insanity, based on the character and circumstances of the crime, was fully brought before them, and they rejected it. We cannot say that they were wrong. But supposing that they were wrong, was their error due to the

terms in which the law was stated to them by the Judge? The Judge told them that as to the atrocity of the crime being itself a *proof* of madness, no such inference in law arose. Beyond question the Judge was right, not only legally but scientifically right. He did not say that great atrocity in the crime was not *evidence* of madness. There is no doubt that there are cases in which it may be so regarded, but that it should, standing alone, be of itself accepted as proof of insanity cannot for a moment be admitted. The jury were at liberty, if they so chose, to regard the exceptional atrocity of the crime as *evidence* of insanity, and, if it were sufficiently corroborated by other evidence, to find the prisoner insane. They did not find the other evidence sufficient. Ought they to have done so?

3. The other evidence was twofold. (1) The history of epilepsy. (2) The medical evidence. The history of epilepsy was very weak. One witness, the stepson of the murdered woman, stated that he had seen the prisoner twice in paroxysms of epilepsy in the early part of the year, months before the crime; but the Judge drew attention to the fact that other witnesses, who had known the prisoner well for years, had not been asked a single question as to whether he had suffered from fits. Two medical men swore positively that they had seen the prisoner sham fits. He had been discharged from the militia ostensibly on account of epilepsy, but the militia surgeon also had accused him of shamming. The surgeon to the gaol had, however, seen him in several fits, which appeared to be genuine. This was the whole of the evidence of epilepsy, and while, if we believe that he did suffer occasionally from fits, it may add some degree of probability to the evidence in favour of insanity furnished by the character of the crime, on the other hand the evidence of shamming, coming as it did from three independent sources, must have told, and rightly told, very powerfully in the opposite direction with the jury. They would naturally and properly argue that a man who would thus very shortly after the crime endeavour to manufacture evidence in favour of insanity, might well have been prompted by the same motive in appearing, as he did, naked and bleeding at the police station immediately after the crime. We cannot see that the jury had, upon the evidence, any alternative to rejecting the evidence of epilepsy, and regarding it as, if anything, strengthening the case against the prisoner; but they were perhaps confirmed in this view by the statement of the Judge that "epilepsy and insanity were, in the medical sense, as far as the poles asunder." This, it will be observed, was not a statement of the law which the jury were bound to observe. It was a medical opinion, and is interesting as showing that the medical opinions of judges are no more trustworthy than the legal knowledge of doctors. It may have had weight with the jury, but they had already ample reason to discount the evidence of epilepsy, and against the Judge's medical opinion they had the opinions of medical experts, which they were doubtless quite capable of weighing against that of the Judge. So far, we do not find that the conclusion of the jury was wrong, nor that, if wrong, it was due to any statement of the law by the Judge.

4. We now come to the medical evidence. Altogether, five doctors gave evidence: Dr. G. P. Godfrey, Surgeon to the Police; Dr. P. L. Robinson, Medical Officer of the Workhouse; Dr. Owen Taylor, Surgeon to the Gaol; Dr. Nicolson, of Broadmoor; and Dr. Powell, Superintendent of the Nottingham Borough Asylum.

It does not appear that any unreasonable restriction was placed upon the evidence of the medical witnesses. On the contrary, Dr. Nicolson was allowed to say that, in his opinion, the prisoner at the time of committing the crime did not know what he was doing. In allowing this opinion to be given, the Judge relaxed the rule of evidence in favour of the prisoner. The only occasion on which the Judge interfered in the medical evidence was when a witness was asked if the prisoner had the power to resist evil. "How can he say that?" said the Judge; and it must be admitted that the interference was not unreasonable. Unrestricted as they were, the strongest evidence in favour of insanity that could be obtained from the medical witnesses was the statement of Dr. Powell that the prisoner was a weak-minded man, considerably confused in his mind, and very depressed. Ought the jury, on this evidence, to have found the prisoner insane? A man

awaiting his trial on a charge of quadruple murder is scarcely likely to be in high spirits. He may even be very depressed without exceeding the bounds of the normal. Is he to be considered irresponsible because he is weak and confused in mind? To this the only possible answer is, that it is a question of degree, and that the degree of weakness and confusion of mind that carries irresponsibility can be determined by the jury alone.

Dr. Nicolson's evidence was that he had no reason to think that at any time the prisoner was insane.

Thus, upon a careful examination of the evidence, we find that the reason why the plea of insanity failed was that the evidence was not sufficient to substantiate it. The failure was not due to any undue narrowness in the law, nor to any rigidity of interpretation of the law by the Judge, but simply and solely to insufficiency of evidence, and the conclusion at which we arrive is that the prisoner was rightly convicted.

Reg. v. Tinkler.

Jane Tinkler (24) was indicted for the murder of her child. She had tied an apron string tightly round its neck and thrown it into the river. Counsel for the prosecution, in opening the case, said that the Treasury had instructed Dr. Smith, of Sedgefield Asylum, to carefully watch and examine the state of mind of the prisoner, and he was of opinion that she was not able to plead or to understand the plea. Another doctor had also examined her, and said she had sufficient intelligence to understand the trial. He proposed to put both doctors into the box. His lordship said that if one doctor said one thing and one another he could have no hesitation in saying that the prisoner could and would have to plead. The plea having been taken, counsel for the Crown (Mr. Hans Hamilton) detailed the facts, and told the jury that he thought that their verdict would be that when she caused the death of her child she was of unsound mind.

The facts being proved, Dr. Renton deposed that in his opinion the prisoner was insane. She was undoubtedly of unsound mind.

Dr. Smith was decidedly of opinion that prisoner was of unsound mind when she committed the deed.

Dr. Gilbert (gaol surgeon) had no doubt that prisoner was insane when she committed the deed.

The jury found the prisoner guilty, but not responsible for her actions.—Durham Assizes, Nov. 20 (Mr. Justice Grantham).—"Newcastle Daily Leader," Nov. 25.

The medical evidence in this case was very remarkable. The medical witnesses were allowed to say not only that the prisoner was insane at the time of trial, but that she was insane *when she committed the deed*.

Reg. v. Forde.

This was the case in which a man ran "amok" in a common lodging-house at night, wounding four persons. The evidence showed that the prisoner with six other men slept in one room. About midnight a man who slept in the same bed with prisoner roused the rest by crying "murder." A light was struck, and the prisoner was seen to rush at one Thrustle, who was still in bed. Thrustle fled, but prisoner pursued him out of the room and down the stairs, stabbing him, in all, six times. Prisoner ran off in his shirt, and at half-past five next morning presented himself at the police station, stating that he had stabbed five or six men who had been following him all night with lights. He had then a knife in one hand and a pricker in the other.

Dr. Arbuckle proved that about the time of the occurrence the prisoner suffered from delusions, and that, on the morning on which he was locked up, he declared that he had been running about all night pursued by thirteen or fourteen poachers. The Judge is reported to have told the jury that the main question for them was whether the prisoner was responsible for what he did. The jury found the prisoner guilty, but insane.—West Riding Assizes, Dec. 4 (Mr. Commissioner Forbes, Q.C.).—"Yorkshire Daily Post," Dec. 5.

Reg. v. Dixon.

Prisoner, a labourer, æt. 53, was charged with the murder of Margaret Appleton, cook at Bedale Workhouse. The deceased went into the garden where prisoner was digging potatoes, pulled the fork out of his hand, and struck him. Prisoner retaliated, with the result that the woman died. He pleaded guilty of manslaughter, and the plea was accepted. In mitigation of sentence it was urged that, although the prisoner was not insane, his mind had become affected by extremely sad domestic troubles, so that on receiving great provocation from the deceased he was not able to exercise a reasonable faculty of discrimination. He lost his wife in 1891, and was left with a family of six young children. Having to attend to his family and nurse a sick child, he lost his situation. Subsequently a daughter eleven years old was criminally assaulted, and under the accumulation of troubles he attempted to commit suicide. He was then removed to the workhouse, and on improvement was discharged. Becoming worse again, he was readmitted to the workhouse, and then the incident took place for which he was now tried. He was sentenced to five years' penal servitude. The Judge said that he felt justified in treating the case as one in which there was some provocation, but he does not appear to have given any effect to the plea of unsoundness of mind, though it appears from the report to have been a case in which the plea was well substantiated.—Yorkshire Assizes, York, Dec. 1 (Mr. Justice Grantham).—"Leeds Mercury," Dec. 2, 1895.

Reg. v. Gamble.

Alfred Gamble, 17, labourer, was indicted for wounding a child named W. C. Cattle, with intent to murder. The case excited great interest on account of the fact that another young child had recently been murdered in the same neighbourhood, and although there was no legal proof of the fact, there can be little doubt that the prisoner was the culprit in that case also. The body of the first child had been found in a dustbin, enveloped in a sack. The second was found, badly wounded, concealed in a stable. The prisoner was found unfit to plead. The case belongs to the same group as the Plaistow murder—that of crimes by "instinctive" juvenile criminals.—Central Criminal Court, Jan. 15 (Mr. Justice Hawkins).—"Times," Jan. 16, 1896.

Barnard v. Garrard.

This was an action for breach of promise to marry, the defence being that at the time the promise was made defendant was of unsound mind, and if not then of unsound mind became so before the time for fulfilment arrived. The admitted promise was made in January, 1895. On the 6th of February following the defendant was in a state of intense maniacal excitement, and on the 8th was sent to Heigham Hall, but no evidence appears to have been given that he was insane in January, nor were the medical men who saw him in February asked as to his probable condition in the previous month. The jury found that defendant was of sound mind when he made the promise, but of unsound mind at the date fixed for the performance, and assessed the damages at £500. The judge thought it a perfectly right finding, but said that as a matter of law judgment would be for the defendant.—Q. B. D., Feb. 13 (Lord Justice A. L. Smith).—"Daily Chronicle," Feb. 14, 1896.

HOLLOWAY SANATORIUM.

Report of Result of Inquiry by the Commissioners in Lunacy.

In pursuance of a direction by the Board, we, the undersigned Commissioners in Lunacy, together with our late colleague, Mr. Charles Palmer Phillips, whose sudden death we all so greatly deplore, and our colleague, Dr. Southey, who was present on the first two days, but was prevented by illness from attending our adjourned meetings, on September 26th ultimo opened an inquiry at the Holloway Sanatorium, which was resumed on the following day, and then adjourned to the 24th instant.

We were directed to inquire generally into the medical and other administration of the Sanatorium, and specifically into various allegations of neglect or maladministration which appeared in the pages of "Truth," a weekly newspaper. The inquiry was adjourned in order to communicate with the friends of the patients whose cases were the subjects of those allegations, and to invite them, if they desired it, to attend the inquiry.

Under the power conferred by Section 332 of the Lunacy Act, 1890. we summoned the following persons to appear before us and give evidence, viz. :—(1) Jane Buchanan Henderson, Dr. Charles Caldecott, Miss Bessie Jupe, and Miss Bertha Topham Jones.

Mr. Frank Squire, the husband of a lady patient who had escaped from the Sanatorium, was the only person who, in response to our invitation, attended to offer evidence of alleged ill-treatment. Miss I —, the sister of a lady patient who was alleged to have been scalded in a bath, attended, but stated that she had no complaint to make of her sister's treatment in the Sanatorium, but was quite satisfied with that treatment. Mr. Squire was accompanied by his solicitor and his counsel, Mr. Bonsey, who examined him, and whom we allowed to cross-examine the other witnesses who gave evidence in the case.

The case of Mr. Thomas Weir, largely commented on in "Truth," was excluded by the Board from the scope of our inquiry, it being considered that the former sworn inquiry by two members of our Board, the inquest, and the inquiry conducted by Mr. Gully, Q.C., and Dr. Savage, had elicited all the information regarding it possible to be obtained.

We should state that, as the Board are aware, most of the other cases referred to in "Truth" had already been inquired into and dealt with by the Board, although evidence on oath was not taken upon the inquiries.

Our adjourned inquiry occupied two days. During the inquiry we examined on oath four members of the Committee of Management, six present or former members of the medical staff, the accountant, the auditor, six present or former members of the nursing staff, the hall porter, and Mr. Frank Squire, the one complainant who came before us. We also examined, but not on oath, two patients, and the voluntary boarder, whose visit to Epsom had been the subject of comment.

We propose to deal, in the first place, with the cases and matters specifically referred to in "Truth," stating the conclusions at which we have arrived.

1. The Case of Mr. J. A. L., stated to have been discharged from the Sanatorium suffering from a bed sore.

No person attended on behalf of the friends of this gentleman. He was admitted to the Sanatorium on January 6th, 1891. He had previously been a patient at St. Andrew's Hospital, Northampton, and afterwards in his own house. He was suffering from general paralysis of the insane and was "wet and dirty." Towards the end of the month of January a bed sore, described as "acute," developed over the sacrum, and is stated in the "case book" to have been dressed with "liq. carbonis detergens." An entry in that book under date of February 27th states that "the sore is granulating up well;" and in a further entry, dated March 14th of the same year, it is stated that "the bed sore is almost entirely filled up." On that day the patient went home in charge of his wife "on trial." There is no doubt that he was then suffering from the bed sore. Dr. Philipps stated to us in his evidence that the sore was "trophic," and not one arising from defective nursing; and that the patient was subject or liable to such sores; in proof of which statement he produced to us a letter to him from the patient's wife, dated January 12th, 1891, and enclosing an account in her handwriting of the patient's previous history, in which she said, referring to the year 1886, "I then found that a large abscess (of which I was unaware) had evidently just burst at the end of the spine." Dr. Philipps further swore that he had, within a few days prior to Mr. L.'s discharge on trial, seen the bed sore, and that it was then in a healthy granulating state, the granulations being nearly up to the surface. Dr. Nuthall, now an Assistant Medical Officer at the Sanatorium, and at the above date a Clinical Assistant there, stated in his evidence that he remembered the case of Mr. L., and that he agreed with Dr. Philipps as to the bed sore having

been "trophic," and not of the ordinary kind, and he was sure it was not one arising from defective nursing.

In the absence of evidence to the contrary, we arrived at the conclusion that the bedsores in question was of the character described, and it is a matter of common medical knowledge that persons suffering from general paralysis are more than ordinarily liable to complications of that nature.

It is but fair to Dr. Philipps to state that in 1891, when this case was the subject of correspondence with our office, he courted a formal inquiry into it, but this was not considered necessary by the Board. Also, that although the patient was removed in March, no complaint of ill-treatment or neglect was made to this office until the middle of June, and in the interval differences had arisen between Mrs. L. and the authorities of the Sanatorium respecting the account of charges which had been presented to her. There appears to have been misapprehension with regard to these charges, which ought to have been avoided by a clearer statement of their nature and amount, before the reception of the patient. We are informed that greater care is now exercised, and more precise information afforded in regard to this matter. In the correspondence between Mrs. L. and Dr. Philipps, occurred a statement by the latter that the sore "was one of many from which Mr. L. was suffering when he came here," meaning the Sanatorium; but that was not the fact, and the misstatement was subsequently explained by Dr. Philipps to have arisen from a misunderstanding on the part of a shorthand clerk to whom he had dictated the letter in which it occurred, he, Dr. Philipps, having signed the transcript without careful examination.

2. The Case of Mrs. Squire, who had escaped from the Sanatorium on January 24th, 1893.

As already mentioned, Mr. Frank Squire, the husband, attended our inquiry, and he was examined at considerable length by his counsel, and was also examined by us.

The fact of the escape was not called in question. The evidence showed that it was effected by the patient from a "strong room," having a window secured at night by shutters, which, through negligence, were left unlocked on the night of the 23rd. Mrs. Squire opened the shutters, tore down a portion of the upper sash, which was hinged and could be opened for ventilation, and escaped through the aperture. The housemaid whose duty it was to lock the shutters, but had omitted to do so, was dismissed, and the charge nurse, who should have made sure that the shutters were locked, was deprived of an advance of wages to which she had become entitled.

Mr. Squire complained of this and of several other matters connected with his wife's treatment, the principal being that he was not informed in due course of her escape; that he had not been informed of her having received a black eye, and having developed erysipelas, before he observed these facts himself on a visit to the Sanatorium; that he was for some time refused inspection of the rooms she occupied, but was eventually told he might have it on payment of a contribution of £1 to a pension fund; that his wife had been placed in a bedroom without the usual toilet appliances and had had to perform her toilet in a lavatory; that another bedroom occupied by her was damp and not suitably furnished; that a statement that his wife had attacked and knocked down a nurse was untrue; that a small brooch sent by him as a birthday gift to his wife was withheld from her, and that nurses treated his wife roughly.

The inquiry into this case occupied us during several hours. Our conclusions are: (1) That Mr. Squire ought to have been immediately informed of his wife's escape. This is admitted by Dr. Philipps, who expressed his regret at the omission, and also by the Committee. (2) That it would have been more judicious on Dr. Philipps' part to have informed Mr. Squire that his wife had received the black eye, which, it was stated, was sustained in a quarrel with another patient, who struck Mrs. Squire. (3) That Mr. Squire was not entitled to demand, as of right, inspection of the rooms occupied or used by his wife while a patient in the Sanatorium, but that it would have been judicious on the part of the Superintendent, in the absence of strong reason to the contrary, and which did not appear

n the evidence, to have permitted the inspection sooner, and that coupling the eventual permission with the suggestion of contributing to the pension fund (which we were informed does not exist) was most ill-judged and improper. (4) That the removal of articles of furniture from the bedroom occupied by an insane patient may be a very proper course to adopt, and must depend on the mental condition of the patient, which, in Mrs. Squire's case, as disclosed by the evidence, was, in our opinion, such as to justify its adoption.

We were informed that the lavatory accommodation in the gallery in which Mrs. Squire was placed was at the time too scanty, but that the deficiency is now supplied.

(5) That the bedroom complained of as being damp had some of the wall paper discoloured by a leakage, but was not, in fact, damp when Mrs. Squire was placed in it, and that the bed and bedding complained of was similar to that generally in use, and was sufficient and of good quality. (6) That the brooch was withheld upon grounds connected with Mrs. Squire's proneness to attempt escape, as to the adequacy of which the Medical Officers were fully entitled to exercise a discretion. (7) We pressed Mr. Squire to give us instances of roughness to his wife on the part of nurses, but those he adduced did not amount to more than the employment of a somewhat peremptory tone in the utterance of such phrases or orders as—“Come along, Mrs. Squire,” and “Now, Mrs. Squire, Mr. Squire must be going,” these being the phrases which he quoted. We always desire to inculcate and enforce a respectful manner and address by attendants, who are necessarily placed in a position of authority over persons in a superior social station; but in the present case we do not think that Mr. Squire's evidence supported his charge of roughness or want of respect towards his wife on the part of the nurses. Mr. Squire also complained that on an occasion when he was leaving his wife at the lodge gate, and she was reluctant to return to the building, the hall porter, who had been summoned to assist the nurses, took hold of Mrs. Squire by the legs. This the hall porter, Butler, denied on oath, and informed us that Mrs. Squire had on that occasion kicked him in the groin, causing a rupture, for which Mr. Squire afterwards compensated him by a present of £20, which the Committee allowed him to accept. He added that Mrs. Squire was attempting to kick the nurses, and that had he not been prevented by the kick which he himself received he would, for the nurses' protection, have seized Mrs. Squire by the leg.

We learnt from Mr. Squire and from members of the Committee that the former had, on April 17th, 1893, a long interview with the Committee, who gave him a very full and patient hearing, and expressed their regret at the omission to send notice of the escape, and their disapproval of the suggestion of giving a contribution to the pension fund, and requested him to take back the cheque. On his refusal to do so, the cheque was torn up and burnt. The Committee also communicated their disapprobation of the incident to Dr. Philipps, who acknowledged the error.

As regards the alleged misstatement that Mrs. Squire had assaulted a nurse, the facts, as appearing from the evidence, were that on an occasion when Mrs. Squire had to return to the galleries from the entrance hall after an interview with her husband, she resisted, and was led away by two nurses, one on each side, having hold of her arms, and that she wrenched her right arm free and struck the nurse on that side (Miss Ethel Ross) on the chest; the nurse's foot slipping at the same time, she fell. In a paper prepared by Dr. Moore, the Senior Assistant Medical Officer, for Mr. Squire, it was said that on the occasion (February 24th, 1893) in question Mrs. Squire “attacked Miss Ross and knocked her down in the corridor.” This statement was certainly stronger than the facts as elicited by us justified; but it was true that Miss Ross was struck by Mrs. Squire, and that she fell. No great importance is attachable to the incident.

We may add that on January 31st, 1893, Dr. Philipps proposed to Mr. Squire to remove his wife to another institution, and gave him the names of two licensed houses, but she was not removed until April 21st, 1893, when she was taken home, but placed in St. Andrew's Hospital on the 26th of the same month on an Urgency Order, the reason given for urgency being the fear of the certifying practitioner “of her doing injury to her husband and his daughter.”

3. The alleged use, for the occupation of patients, of two "tumble-down" cottages.

These cottages had frequently been seen by Visiting Commissioners on their rounds of inspection, and while occupied by patients they were in proper repair, and not considered unsuitable for their purpose. The cottage referred to as the "Cement Room" was never used, we are informed, as a store until after it had ceased to be occupied by patients; and we interviewed an intelligent patient (Mr. V.) who had occupied it, and who told us he had found it very comfortable, and regretted being removed from it to the Retreat, on the completion of the latter. It was, we believe, in the second of the two cottages, which adjoins the first, that the patient lived who is referred to as living like a "hermit." He was well known to members of our Board as an eccentric but quite harmless individual, who was allowed considerable liberty and indulged in many of his fancies, and we have every reason to believe that he was always kindly treated. We are informed that he has been discharged, and is now living by himself in the neighbourhood.

The person referred to as being "apparently not much short of 80 years of age" is supposed to have been the Rev. G. C. C., whose age at death was 53. He had been employed in the garden, with other patients, and had wheeled a barrow. His death was not sudden, but occurred after 12 days' illness from influenza and three days' from diarrhœa. The outdoor employment of private patients in gardening, or work connected with it, has our entire approval, as being remedial in its effect, or at all events calculated to improve physical health, and afford pleasant occupation.

With the patient boarded out at Stroude, which is a hamlet immediately below the Sanatorium, we had an interview, when he described to us the incident of the boots, and admitted that he had walked from Egham on a frosty day, barefooted, and with his boots slung round his neck. He gave us as his reason for doing so that the boots were new and hurt his feet, that he was a seafaring man, and had been accustomed to going barefoot on board ship, and that on the occasion in question he found it easier to go barefoot than to wear the boots. His residence at Stroude was with his father's approval; and he told us he had been very comfortable, and would regret leaving, as had been decided he should do. He had previously been lodged in the so-called "cement room," and he said that it had never been used as such, or in any way as a store, while he occupied it.

In connection with this case we may refer to a practice which we found to exist of "boarding out" persons, some being patients, some nominally voluntary boarders, and others not apparently possessing either character, the hospital receiving a weekly sum for maintenance, and paying thereout a less sum to the person in charge, the balance going to the credit of the hospital, and being, in part, expended in some way for the "boarded out" person's benefit. The sum paid to the hospital is usually 25s. a week, 20s. being given for the board and lodging of the patient. Such persons are in a very anomalous position as regards their legal status, and we must express our disapproval of the practice.

4. The Number of Suicides.

There have been since the opening of the Sanatorium in 1885, four suicides there of certified patients, and one of a voluntary boarder, Mr. Milne. There have also been four serious attempts at suicide. The suicide of a servant took place after she had left the hospital service, and taken away her boxes. We are informed that she had not, to the knowledge of Dr. Philipps, previously manifested any suicidal tendency. Mr. Milne, who committed suicide away from the asylum premises, as a boarder had his parole to go unattended within certain limits, and was about to leave the hospital altogether. Immediately previous to this he was described to us as having been apparently cheerful and in good spirits, and he had not at any time been considered suicidal; his sick leave from his employment as a School Inspector was about to expire, and it is surmised that doubt as to his future, and distrust of his capacity to resume work, led him to commit the act.

There is no doubt that the suicides and attempts at suicide were so numerous as

to indicate a grave want of care; and it will be in the recollection of the Board that it was decided during a considerable period, that Commissioners' consent to transfer of suicidally disposed patients to the Sanatorium should be withheld. All the cases referred to were the subjects of inquiry by the Board at the times of their occurrence, and, in some instances, of censure of the medical staff.

5. The Case of Alleged Scalding of a Lady (Miss L. I.) while in a Continuous Bath.

As already stated, this lady's sister attended our inquiry, but preferred no complaint. We examined in reference to this case the lady nurse, Miss Bertha Topham Jones, who was in attendance on the patient when the scalding is alleged to have occurred; Dr. Charles Caldecott, then an Assistant Medical Officer, who was summoned to the patient; Dr. Miss Jane Buchanan Henderson, of Glasgow, the Lady Assistant Medical Officer at that time who assisted in the post-mortem examination of the patient's body; and Nurse Lydia Barrett, now of Bournemouth, who prepared the body for burial, and we are satisfied that no scalding took place. On the occasion referred to, which was on June 23rd, 1891, Miss Jones, noticing a change in Miss I.'s appearance while in the bath, called loudly for the charge nurse, who came immediately and the lady was lifted out of the bath, having then actually fainted. Dr. Caldecott was summoned, and found Miss I. gasping and apparently moribund; he gave her hypodermic injections of brandy, and applied other remedies, but she remained unconscious till her death, which occurred about twenty-four hours after. All the persons examined swore positively that there were no symptoms indicating scalding, or signs on the body of scalding having occurred, and the causes of death, as ascertained by the post-mortem examination, were stated to be "Pneumonia and Acute Mania." The pneumonia was not diagnosed during life.

The use of the continuous, or prolonged, bath is held to be very advantageous in certain cases of maniacal excitement, and its employment at the Sanatorium is declared by Dr. Philipps to have been attended by very beneficial results. While not expressing any opinion as to its value, we do not condemn its use under proper conditions. The Board's views as to these conditions are indicated by the recently issued regulation as to means of mechanical restraint; and we were glad to learn that at the Sanatorium neither the prolonged bath nor any other form of mechanical restraint is now employed without previous consultation between Dr. Philipps and the Assistant Medical Officer having immediate medical charge of the patient for whom it is proposed to be employed.

6. The Case of the Gentleman who went to the Derby.

We examined this gentleman, who was, and still is, a voluntary boarder. He was intelligent, and gave us a very coherent account of his adventures at Epsom. He at that time resided in the Sanatorium, and was allowed to go at his will anywhere within three miles of the building. He told us he had alternate "good" and "bad" days, the occasion on which he went to Epsom being a "good" day. Having carefully considered his account, and the circumstances of the case as established by other evidence, we must conclude that greater care should have been taken of this gentleman at Epsom, and that he should not have been allowed to wander about the course, as he did, unattended. It seems to us that neither the Committee nor the Medical Superintendent sufficiently realise their responsibility with regard to boarders—a responsibility which is, we think, similar to, and not much less than, that under which they rest in respect of certified patients.

7. The Case of a Servant removed to the Egham Cottage Hospital.

Dr. Philipps and Dr. Moore stated to us that the removal was decided on with a view to surgical operation, the man being suspected of suffering from grave brain mischief, and it was thought that an operation to remove the evil afforded the only chance of saving his life. In fact, the man had an abscess on the brain. We find no ground for blame in this case.

8. The use of the "Dry Pack" as a Labour Saving Appliance.

We have not discovered, and do not believe, that the dry pack was used for that purpose, or with that motive, or otherwise than as a mode of treatment.

9. The alleged parading of Night Nurses to deceive Visiting Commissioners as to the Strength of the Staff.

We examined several witnesses as to this, and all absolutely denied the practice, which, indeed, is most improbable, and could hardly have escaped immediate detection had it existed. The only fact to lend colour to the charge that came to our notice is that frequently on the visits of Commissioners some additional nurses have been for the moment drafted from other galleries to No. 5 gallery, in which are warded the more maniacal female patients, who are apt to become excited by the presence of strangers. The night attendants of each sex live and spend their days out of the hospital.

We may here mention that the allegation that on the night of Mrs. Squire's escape there was a dance or other entertainment for the staff is positively denied.

10. The Certification of Boarders.

The Holloway Sanatorium is an "Institution for Lunatics as defined by the Lunacy Act, 1890," and persons who go there as voluntary patients for treatment (in other words as boarders) do so because of some degree of mental affection or insanity. The question whether they should be admitted in that character or as patients under reception orders depends on the degree of insanity. If a person is undoubtedly insane to the extent that no medical practitioner of experience could have any difficulty in signing a certificate of insanity, then the reception order, is a breach of the Act, and constitutes a misdemeanour. At the Sanatorium Visiting Commissioners have too frequently found that persons residing as boarders fall under the above description, and the Board has felt obliged in many instances to exercise the power conferred by section 20 of the Lunacy Act, 1891, and to require that boarders shall be removed, or that orders for their reception as patients be obtained. We believe that most of the boarders in the Sanatorium who have been certified have been so certified at the instance of Visiting Commissioners or by order of the Board. The tendency of the Sanatorium authorities, therefore, has been to avoid certification rather than to unduly or unnecessarily cause boarders to be placed on the footing of certified patients. For obtaining a reception order a petition must be presented by a person of full age, preferably, but not necessarily, a relative, who has seen the patient within fourteen days before the presentation of the petition. This last condition at times interposed a difficulty when a boarder's relatives resided abroad or at a distance from the Sanatorium, and for this cause was it that in some cases petitions were signed by a clerk of the hospital. The proceeding is certainly unsatisfactory, and only to be resorted to in cases of absolute necessity, and we are assured that it is not now permitted at the Sanatorium without previous reference to our office. In all cases in which it has been done relatives or persons more nearly connected with the patients have by the Board been substituted for the clerk, who by such substitution ceased to have any power of control over the patient. The suggestion that a neighbouring magistrate is not an "independent public authority" is one to which we cannot give the slightest countenance, but must completely disregard.

11. The signing of Certificates of Insanity by a discharged medical patient (Dr. S.) while residing as a boarder.

The Board will, we are sure, agree with us that this practice was extremely improper. This gentleman, between July 24th, 1888, and February 8th, 1889, signed 25 certificates of insanity, but when the practice came to the knowledge of the Committee they at once stopped it, and no certificates were signed by him after the latter date and while he resided in the Sanatorium.

Dr. S. was medically qualified; he had been discharged "recovered," and during his residence as a boarder had professionally attended the wives and families of attendants. We believe the permission given him by Dr. Philipps to sign certificates was given with no other motive than a desire to confer some pecuniary benefit on Dr. S., whose circumstances were narrow. The certificates themselves were not questioned in our office as being in any respect insufficient, and in them Dr. S. described himself as of "St. Ann's Heath, Egham, Surrey,"

which address did not of itself suggest residence in the Sanatorium, so that in examining the copies sent to our office no suspicion of such residence was aroused. Had it been, we doubt not that the impropriety, in the circumstances, of his signing certificates would have been pointed out and the practice stopped by the Board.

12. Alleged insufficiency of the Staff.

We are of opinion that there is no ground for this allegation, either as applying to the present time or to former periods in the history of the Sanatorium. The sufficiency of the staff has always been a subject of inquiry at visits of inspection by members of our Board, and the reports of those visits do not contain any complaint of inadequacy, except on one occasion, when the night nurses were thought to be too few.

We have been furnished with a list of the staff as it existed on September 25th, 1895, and find that there were: For the male division, a head attendant and his deputy, seven gentlemen's companions, 48 day and eight night attendants, a carpenter attendant, and three housemaids, a total of 69 persons; and for the female division, two chief nurses, one deputy chief nurse, 41 lady nurses, 13 nurses, and 26 housemaids, a total of 83 persons. At the same date, there were residing in the Sanatorium 144 male patients and boarders, and 167 female patients and boarders, and at Hove Villa, Brighton, a branch establishment, 18 gentlemen and 19 ladies of the two classes, four members of the male and nine of the female staff being then there employed. There was, therefore, for the charge of the 144 gentlemen and 167 ladies in residence in the Sanatorium on the 25th of September, 1895, 311 in all, a staff consisting of 139 persons, which, for domestic work, was strengthened by the employment of some so-called "after-care" cases, of whom there were 12. These are persons who had been patients in different institutions for the insane, and had recovered, but for whom it is difficult at first to find employment. They are maintained for a time in the Sanatorium in return for their services, but receive no wages, and we consider the system worthy of all praise as a work of true charity.

We were informed by the members of the Committee that Dr. Philipps has absolute discretion as to the strength of the ordinary staff, with powers of engagement and dismissal of its members, but that the medical staff can be altered or increased only with the concurrence of the Committee. The wages paid to attendants and others are, we think, liberal.

13. As to Dr. Philipps' position.

In his evidence before us Dr. Philipps modified his statement in regard to his position quoted in Mr. Gully's report, viz., "that he did not consider himself in active medical charge of the establishment, but looked upon himself more as the consultant physician." He stated to us that he held himself to be solely responsible, under the Committee, for the medical and general administration of the institution, and in the same position as any Superintendent of an asylum who has Assistant Medical Officers, the practice being for the ordinary routine of medical treatment to be carried on by the Senior Assistant Medical Officers in their respective divisions. He added that his Assistant Medical Officers only consulted with him in cases of importance, or as to which they had any doubt, but he held himself responsible for the medical treatment which he directs and controls.

To this definition of his position as Medical Superintendent we do not object. We think that in practice there has been too much of the detail of treatment, medical and other, left to the discretion of the Assistant Medical Officers, but we are assured that in future there will be regular consultation on cases, and more direct and immediate control of treatment by Dr. Philipps. There is no doubt that this is extremely desirable.

14. Discussion of the Accounts of the Sanatorium.

We must premise that the accounts discussed in "Truth," as taken from our annual reports for 1893 and 1894, are not balance sheets, the form of hospital accounts there published being merely that of cash accounts of receipt and payments, and they are given solely or mainly for the purpose of comparison between

several Institutions. They consequently afford no information as to the disposal of surplus income, or as to profit and loss.

We do not agree that the expenditure on structural work at the Sanatorium has been extravagant. As was stated in our 40th report (for 1885), the building "was not designed most suitably or conveniently for its purpose, and in particular did not include any well-contrived department for the treatment of excited cases." The deficiency had to be supplied, and many alterations, in great part suggested, and all approved by our Board, had to be effected at a considerable outlay, which was supplied out of surplus revenue; and from a return furnished we learn that up to the end of 1894, £38,185 were so provided and expended. We fear that the outlay in this direction has not yet reached its limits. The hospital is well, but not, in our opinion, too luxuriously furnished, for we must approve of anything in reason that adds to the well-being and comfort of the patients. In this connection we may state that the accounts of the hospital show that the average weekly expenditure per patient has increased from £1 15s. in 1887 to £2 1s. 10d. in 1894.

The hospital accounts are audited by a chartered accountant whose appointment is approved by our Board, and he gave evidence before us that they are carefully kept, and duly vouched. It is almost unnecessary to add that the members of the Committee whom we examined, assured us that no one member of that body had any pecuniary interest in the Institution, and the Medical Staff, none beyond their salaries and recognised emoluments; and in addition, the auditor testified that no payment other than the foregoing was ever made.

The Board is aware that the charitable element in the administration of the Sanatorium is governed by a scheme sanctioned by the Charity Commissioners, which provides that a certain proportion of the patients shall be received and maintained at considerably less than their actual cost, one half being received at charges not exceeding 42s. per week, and one half of these at charges not exceeding 25s. per week.

Evidence has been given which satisfies us that this condition is fully observed, and it appears that in 1894, charitable assistance, taken as the difference between the sum of the maintenance rates actually paid for this class of patients and the amount which would have been paid had the actual average cost of maintenance per head of all patients been charged, amounted to the sum of £6,560 7s. 3d.

We have now dealt with the various allegations of the periodical in question, and with the personal complaints of Mr. Squire, and, as the result of our inquiries, and the evidence given, we consider some to have had reasonable foundation, but the majority to be unfounded or resting on very slight and unimportant incidents.

It remains that we should offer some remarks on the general administration of the Sanatorium.

We questioned the members of the Committee who gave evidence, as to the amount of supervision exercised by the Committee of Management, and we were satisfied that many members of that body take an active part and interest in the affairs and administration of the Institution, which they to a very considerable extent control. It would, however, be impossible for a Committee to exercise a very minute control. The details of administration and the whole of the medical and other treatment of the patients must necessarily be left in the hands of the Medical Superintendent, and a too officious interference with his discretion would certainly be injurious.

As regards Dr. Philipps' past management, while not overlooking the very arduous task undertaken by him in the organisation from the beginning, and subsequent rapid development of the Sanatorium, and the varied duties in regard to these which devolved upon him, we must express our opinion that the failures and shortcomings which have come under our notice and that of our Commission, have been in a great measure due to want of that close and unremitting personal attention on the part of the Medical Superintendent which alone can ensure the continuously successful management of so large and important an Institution, and also to some neglect of the frequent individual intercourse with, and examination of patients, and careful consideration of their varying condition, which we regard

as essential to their proper treatment. We recognise that in so large an Institution there must be some devolution of the latter duty upon the subordinate Medical Staff, but the Medical Superintendent should still remain in full touch with all his patients, and be thoroughly conversant with the progress of every case. We must add also that there has not been on Dr. Philipps' part the strict observance of the requirements of the Lunacy Law which we regard as most important. We refer more particularly to the reception, as boarders, of persons undoubtedly insane, and who should have instead been admitted as duly certified patients in conformity with the provisions of the Act.

The recently revised Regulations of the Hospital, which will shortly be submitted for the sanction of the Secretary of State, contain a provision requiring the Medical Superintendent daily to visit all parts of the Institution and see every patient, the due observance of which requirement will, we trust, ensure the full and accurate personal knowledge and appropriate treatment of each case, and prevent the recurrence of such defects in administration as have been indicated in the course of our inquiries. All of which we submit to the Board.

(Signed) C. S. BAGOT, } Commissioners in Lunacy.
(Signed) F. NEEDHAM, }

October 30th, 1895.

[On the 14th Feb. the House of Commons took steps for procuring the public issue of the foregoing Report on the motion of Mr. John Ellis.—ED.]

THE CERTIFICATE IN MENTAL NURSING: RECOGNITION OF THE VALUE OF TRAINED SERVICES.

At a meeting of the Committee of the Joint Counties Asylum, Carmarthen, in January last, it was decided that a bonus of £1 10s. should be added to the wages of every attendant in the service of the asylum who should pass the examination for the above Certificate, at the end of each completed year of service after taking the Certificate. The thirteen candidates successful at the examination last May were presented at a Quarterly Meeting with their Certificates, framed by the Committee's directions, and with the medals.

The plan of recognising by a pecuniary addition (varying in amount in different institutions) the value of trained services has been adopted already at several (a dozen or more) asylums.

MALE NURSES (TEMPERANCE) CO-OPERATION.

The report of this Association for the year 1895-6 shows that the average earnings of each member working throughout the year was £101 16s., after paying all expenses. This result, moreover, is arrived at not by excessive, but by moderate charges and a careful limitation of the costs of management, which in too many nursing institutes deprive the workers of a very large percentage of their earnings.

This Association therefore appears to be worthy of support, both by the medical profession and the best class of male nurses.

ASSOCIATION OF ASYLUM WORKERS.

We have been favoured with a copy of the Executive Committee's memorandum to asylum workers.

"The Association has been initiated under the most favourable auspices, and bids fair to become a National movement. The hope is justified that the *Asylum Workers' Association* will, at no distant date, hold a place in the public estimation and regard similar to that held by the *Hospital Nurses' Association*. The Association is fortunate in the many expressions of sympathy and goodwill it has already received from the official and general public.

"President:—Sir Benjamin Ward Richardson, M.D., F.R.S. Vice-Presidents:—The Lord Bishop of London, Cardinal Vaughan, C. S. Bagot, Esq. (Lunacy Commissioner), Dr. Needham (Lunacy Commissioner), Dr. Wallis (Lunacy

Commissioner), Dr. Nicolson (Lord Chancellor's Visitor, President Medico-Psychological Association), the Earl and Countess of Arran, Lord Henly, Lady Wm. Lennox, Sir Stuart Knill, Bart., LL.D. (Ex-Lord Mayor of London), Sir Wm. Broadbent, Bart., M.D., Members of the London County Council, Members of the Metropolitan Asylums Board, Infirmary Medical Superintendents, Asylum Medical Superintendents, the Rev. Henry Hawkins (Chaplain of the London County Asylum, Colney Hatch), Miss Emily Janes (Secretary, National Union of Women Workers.)

"Sir Benjamin Richardson in his address to the London meeting pointed out the chief objects of the Association:—1. To improve generally the status of asylum nurses and attendants. 2. To secure the sympathy and co-operation of all those interested in institutional work and efforts. 3. To provide a 'Home of Rest and Nursing' for those engaged in asylum work—no such Home being in existence.

"He went on to show how much asylum attendants had to bear, and what appalling duties often became their share of work in the human family; what a tax there was upon their energies, and how brief a period of existence, cheered by very little diversity or recreation, belonged to their lives. That was one point—to gain the sympathy of the public. It was for the interest of the insane that asylum attendants should have the highest position compatible with the work.

"In speaking of the 'Home of Rest' Sir Benjamin remarked that the institution is to be maintained by those for whose benefit it is called into existence. The need of repose and change is especially strong in those vocations which, like that of the asylum attendants, involve a constant strain on the nerves; and a permanent 'break down' will, in many cases, be averted if the 'Association of Asylum Workers' is able to carry out the plan of keeping up a place where tired workers among the insane may rest and recuperate.

"It is hoped that the 'Home of Rest' will be ready for the reception of asylum workers in the summer of 1896. It is proposed to rent and furnish a house or houses on the South Coast.

"There is reason to believe that this project will receive sympathetic consideration at the hands of the City Corporations. It is not anticipated that there will be any difficulty in maintaining the 'Home' after it has been established, the number of workers engaged in asylums being large enough to make it self-supporting.

"It is proposed to draw up and issue as occasion requires, a leaflet—'Asylum News'—setting forth the constitution of the Association, mode of election, tenure of office, with lists of members, notices, and other matters of common interest.

"The expenses attendant on the working of the Association will not be great; the subscription of ordinary members is therefore fixed at the nominal sum of 1s.

"The last census gives some 20,000 or more persons employed as male and female attendants in asylums. Assuming that one-fourth only are enrolled as members of the Association, this will give an annual income of £250.

"The Honorary Secretary (Dr. Walmsley, Metropolitan District Asylum, Dartford, Kent) requests that this matter may be brought to the knowledge of the staff of each asylum, and that the names of those desiring to join may be communicated to him."

CORRESPONDENCE.

Re the Lancashire Asylums Board's Pension Scheme.

FROM LANCASTRIAN.

Few will be found to congratulate the Lancashire Asylums Board on their recently formulated pension scheme.

It is to be hoped that the scheme is but a tentative one, as in its present form it is, in most respects, extremely imperfect.

Possibilities there are, truly, but certainties none. The earnest, faithful asylum official has been led to expect, after a period of from 20 to 30 years of difficult, often dangerous, and comparatively ill-paid service, a definite pension according to his service and record. It is well known that the promise of this

pension was taken into account when the various salaries and value of the emoluments were fixed.

Now, forsooth, he *may* obtain, irrespective of his record of good and long service, between 55 and 60 years of age, a pension (*of at least one-third of his actual salary*, or at most of two-thirds of his salary and emoluments), but the actual amount of which depends upon the caprice or temper of the awarding body which may then be in office.

Even apart from these wide limits the scheme is too elastic, every provision being so arranged as to be possibly set aside or to be modified indefinitely. The minimum age at which a pension may be ordinarily granted is fixed by the Lunacy Act of 1890 at 50 years, yet this is overridden and other five years added in this scheme, making the minimum age 55 years. The age for compulsory retirement proposed in this scheme is 60 years. Few attendants on the insane are fit for active duty after 55 years, as long service in an asylum has, without doubt, a markedly deteriorating effect both mentally and physically.

One could name several counties, some of far less extent and importance than Lancashire, where definite and equitable pension schemes have been adopted, and which have given general satisfaction.

Besides Lancashire, the following counties have adopted pension schemes during the last few months:—

Wilts County Asylum.—Only those in continuous contact with patients are eligible for pensions. Minimum age and service is 50 and 15 years respectively. The scale adopted is one-fiftieth of salary and value of emoluments for every year of service up to 20; for each succeeding year up to 25 an addition of two-fiftieths to the above and a corresponding addition for further years of service up to a maximum of two-thirds of annual salary and emoluments. No age has been fixed for compulsory retirement.

Devon County Asylum.—The same restriction as to persons eligible exists. The minimum age and service is 50 and 15 years. The allowances made are not more than one-fortieth nor less than the one-fiftieth of salary and net value of the emoluments for every year served, the minimum being fifteen-fiftieths and maximum twenty-six-fortieths or twenty-six-fiftieths or fraction between these latter points at the discretion of the Committee.

Derby County Asylum.—Rule as to eligibility similar to the above. "A service of 15 years shall entitle an official of 50 years of age to a pension, but no pension shall exceed two-thirds of pay and emoluments at date of retirement." The following standing scale is adopted: One-fiftieth of pay and emoluments per annum for every year's service, with a minimum age of 50 years and a minimum and maximum of service respectively of 15 and 26 or 34 years. Under special circumstances the pension may be one-fortieth, with a maximum of twenty-six-fortieths, but that as to the one-fiftieth scale, persons eligible may claim it as of right. Resignation shall be optional at the age of 50, but compulsory at the age of 55.

Cornwall Lunatic Asylum.—No restrictions as to eligibility. (1) "A service of 15 years shall entitle any officer 50 years of age to a pension." (2) The scheme provides one-fortieth of pay and emoluments for every year's service, with a minimum of age of 50 years and a minimum and maximum of service respectively of 15 and 26 years. No age has been fixed for compulsory retirement.

All the above schemes have provisions for granting pensions earlier in cases of confirmed sickness or disability from injury received in the actual performance of duty.

DR. LOCKHART ROBERTSON'S RETIREMENT.

At a meeting of the Board of the Lord Chancellor's Visitors in Lunacy, held at the Royal Courts of Justice on the 14th January last, the following resolution was passed:—"Resolved that the Board express their regret at the retirement of Dr. Lockhart Robertson owing to impaired health, and further beg to express their appreciation of his distinguished and useful services during a period of 26 years."

JOURNAL OF MENTAL SCIENCE.



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Sir Arthur Mitchell, K.B.

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Dr. Lockhart Robertson's resignation removes a prominent and distinguished personality from the active ranks of our specialty. A slight outline of his past work will, we are assured, be of interest to his fellow associates.

Dr. Robertson's earliest appointment, after a short service as an Assistant Surgeon in the Army, was the post of Assistant Staff-Surgeon to the Military Asylum at Yarmouth, which he held for five years, and during this period assisted the late Dr. Ranking, of Norwich, in preparing his "half-yearly abstract," in which his thorough knowledge of French and German was of great service.

His tenure of office at Yarmouth having expired, he resigned the Army service, entered at Cambridge, graduated as M.B. in 1853, and practised as an alienist physician for four years in London. In 1858 he was appointed Medical Superintendent of the Sussex County Asylum, then in course of erection. This post he held until 1870, when he was appointed Lord Chancellor's Visitor.

His management of the Sussex Asylum was distinguished by marked originality, and soon rendered it one of the institutions to which alienist physicians from other countries paid special attention.

His literary contributions, not only to the pages of this Journal, but to the *Lancet*, *British Medical Journal*, and the *Brighton Medico-Chirurgical Transactions*, were numerous and varied, especially bearing on the treatment and modes of care and accommodation of the insane poor. He also translated, in conjunction with Dr. Rutherford, Griesenger's classical work *Mental Pathology and Therapeutics*, published by the New Sydenham Society in 1867.

With the Medico-Psychological Association his connection has been long and intimate. From 1855 to 1862 he was General Secretary, and from 1862 to 1870 he edited this Journal in association with Dr. Maudsley. In 1867 he was President, and it will be remembered how ably he presided over the Mental Diseases Section of the International Medical Congress in 1881. Even this number of the Journal contains a record of a valuable presentation of books to our latest departure, the library.

This Association, therefore, is deeply indebted to Dr. Robertson for his past services, and its members must unanimously unite in the hope that Dr. Robertson's health may be so restored, by relief from his duties, that he may long enjoy his well-earned and honourable rest.

DR. NICOLSON'S APPOINTMENT.

The succession of our highly-esteemed President to the post of Lord Chancellor's Visitor, vacated by Dr. Robertson, will be generally hailed with intense satisfaction. There is always some apprehension that these appointments may be in a measure biased by personal motives. On the present occasion there can be no doubt that intrinsic merit has decided the question, and we can, therefore, heartily congratulate Dr. Nicolson on the promotion which has resulted from his long and able services at Broadmoor, and the distinguished ability that he has so often manifested.

PRESENTATION TO SIR ARTHUR MITCHELL.

On the 24th of January last, in the library of the Society of Antiquaries, Queen Street, Edinburgh, Sir Arthur Mitchell was presented with his portrait, along with other gifts to Lady Mitchell and himself, on the occasion of his retirement from the General Board of Lunacy. Lord Kinnear occupied the chair, and there was a large and representative gathering of Sir Arthur's friends.

After reading letters of apology for absence, Dr. ROBERT MUNRO, Hon. Secretary of the Committee, read a report recalling the steps which had led up to the present gathering. It mentioned that at a meeting held in December, 1894, under the presidency of Sir Douglas Maclagan, it was agreed that the occasion of Sir Arthur Mitchell's retirement from the Lunacy Board was a fitting opportunity of testifying in some tangible form the respect and regard entertained for him

during his long career of public usefulness. A Committee was appointed, consisting of Lord Kinneir, Mr J. R. Findlay, Dr. Clouston, and Dr. John Murray, with Dr. Robert Munro as Hon. Secretary, and in response to a circular £765 was raised. The Committee commissioned Sir George Reid, P.R.S.A., to paint Sir Arthur's portrait, and Mr. James Faed was also commissioned to execute a mezzotint of the portrait to be presented to each of the 256 subscribers. It was agreed by the Committee to hand 50 guineas to Lady Mitchell to purchase an ornament as a souvenir of the occasion, and to hand over the balance to Sir Arthur for the purchase of books to be added to his library.

LORD KINNEIR then rose to make the presentation. He said he thought it a very great honour to be invited to convey to Sir Arthur Mitchell the sentiments which so many of his friends and so many of his professional brethren desired that he should take with him on his retirement from public office some memorial of their great esteem and regard. He was sure it would be agreeable to Sir Arthur, and, for many reasons, it would be becoming, that he should do so without any kind of preface and in the fewest possible words. They were there to express their personal regard and respect, and these were feelings which they were the least willing to talk about the more sincerely they were felt. He thought he had said enough when he had used these words; but they were there also to express to Sir Arthur Mitchell the gratitude which was due to him for great and memorable public service. That was a topic upon which he had not sufficient knowledge to speak. He had hoped that in the statement which Dr. Munro had just read to them he might have included the views of the profession, which was the best judge, and, indeed, the only competent judge, of the services of Sir Arthur Mitchell in the administration of lunacy. He was fortunate, however, in being able to speak with higher authority than his own, because at the meeting to which Dr. Munro had referred no one could avoid being struck with the extreme unanimity with which the leading members of Sir Arthur Mitchell's profession rose one after another to give their own tribute, and the tribute of those who were unable to be present—the tribute of their professional brethren in all parts of the country—to the services of Sir Arthur Mitchell. And then there was a most admirable and most interesting paper on the administration of lunacy in Scotland, which he wished everybody would read, contributed by Dr. Clouston to an American magazine—a paper which contained such a tribute to the administration of a public body as he very much doubted whether they would find equalled in that kind of literature. He was only repeating Dr. Clouston's words when he said that during the five-and-thirty years, he was afraid, or nearly that, in which Sir Arthur Mitchell had been a member of the Lunacy Board—from the very commencement of the labours of that body—the policy of the Board had throughout been wise and liberal; that it considered from the first the peculiar wants of the country and the peculiar necessities with which it had to deal; that it had done much to advance medical science, much to enlighten the afflictions of the insane, and much to satisfy the just demands of that branch of the profession which was engaged in the management and treatment of the insane; that it had educated public opinion; that it had obtained the confidence of the country; and that in all its dealings with all classes of men with whom it had been brought into contact it had been just, fearless, and generous, so as to earn the gratitude of all persons engaged in the great work the administration of which it controlled, from the great physicians and managers of the leading asylums of this country down to the humblest Inspector of Poor in the smallest country parish. They were not all in the position to have ascertained for themselves the truth of these statements, but he thought they were at least able to value the eulogy of such a man as Dr. Clouston, and they were able to appreciate the great and admirable qualities which must have been combined to enable the Board of Lunacy and its medical members to carry through so anxious and so vast a system of administration for so long a time, and to earn at the end of five-and-thirty years the admiration, the regard, and the respect of the medical community. He was sure it must be an immense gratification to Sir Arthur Mitchell to know that he retired from public service leaving behind him no resentments, no unpleasant memories,

no harsh recollections, but with the cordial goodwill and esteem of a great profession, and the affectionate respect of many of its members. But Sir Arthur had not allowed himself to be absorbed even in so exacting a pursuit as that which had formed the business of his life. He had had time to give to letters, to history, to archæology—they had all read the delightful book which had gained him so high a reputation on that subject—and to public business of other kinds, and he (Lord Kinnear) had during the last few years great opportunities of seeing the admirable tact and judgment and good sense and kindly feeling which Sir Arthur brought to the solution even of troublesome and vexatious problems. Sir Arthur had also, happily for all of them, found time to give to society and to friendship. In conclusion he had to request Sir Arthur Mitchell to accept the portrait just unveiled as a tribute of the great respect and esteem of many friends and many professional brethren, and to tell him at the same time how much they were gratified by Lady Mitchell's having been pleased to accept also some memorial of the esteem in which her husband was held by his brethren. He had only further to express their most sincere wishes for his welfare and happiness in the leisure which they knew would be fruitful, and to hope that this portrait might for many years remain to him, and to those who were nearest to him, as a token of their regard and respect, and that afterwards it might preserve for generations who were to come after him the memory and the likeness of a very perfect, gentle knight.

SIR ARTHUR MITCHELL—Lord Kinnear, Ladies and Gentlemen,—Even persons of ready speech sometimes find it difficult to say what they would like to say. But ready speech is not mine at any time, and just now I know that words must fail me when I try to “deliver the message of my heart.” You have presented to me a princely gift from a crowd of friends, and “I can no other answer make but thanks and thanks,”—thanks unspeakable. My first feeling is one of gratitude for such a token of esteem. If there is pride in my thankfulness, it is not the pride which would make the mixed feeling a base alloy. I *am* proud of what my friends have done. It gives me inexpressible pleasure. But the pride and pleasure are not rooted in any sense of worthiness. The gift comes to me “without deservingness;” and the sense of this has been deepened by the good things which you, Lord Kinnear, in presenting it, have so pleasantly and gracefully said of me—in “words of so sweet breath” as greatly to enrich the gift. This act of kindness has made me realise how much I am a debtor all round—all along the road of my life, down to the present hour. My years, which are now many, have been filled with hard, earnest work. I have loved that work; my soul was in it; I think it had some success; and it gives me pleasure to remember how abundantly I have been helped. I look back on a life which has been full of happiness. Trouble and sorrow have come my way, but happiness has reigned. I have found the world comely, and the name of the helping friends I have met in it is legion. To them I am deeply a debtor. By this day's doings, how greatly is my debt increased! I have spoken of the work of my life, and, in doing so, I have had special reference to that work which was connected with Lunacy Administration in Scotland, England, and Ireland, but particularly, of course, in Scotland. This has been the *work* of my life; but, to my own advantage, I believe, and to my enjoyment certainly, I have had an active interest in other lines of work—for example, in archæology and meteorology. When that interest first arose, I intended it to result only in relaxation or play, but it came soon to be a play which was pleasantly laborious. It is of my lunacy work, however, that I desire now chiefly to speak. In that work I have had the good fortune to be constantly associated with very distinguished colleagues, and I count them all as close and fast personal friends. Of the colleagues with whom I began my lunacy work not one remains. “They have all gone into the world of light.” This is neither time nor place to say more of what Lunacy Administration owes to them than that it is incalculable. Very pleasant they were to me, and their influence and example have done much to shape my life. But I have had the further good fortune in my lunacy work to be in direct and close official relations with a body of enlightened, earnest men, actuated by the very aims which actuated myself, and from whom I was constantly learning. I refer to the Medical Superin-

tendents of the Asylums of Scotland. Among the physicians of the world who are devoted to the care and treatment of the insane many of these gentlemen stand in the very front rank. I have regarded them all as personal friends. This day of days makes memory do "her wonted work," and with tender regret I call to mind those of them "who have fallen on sleep." In the conditions described, it was easy to succeed and be happy. It was not necessary that we, either they or I, should lose the courage of our opinions. We were co-operating—had the same objects at heart; and "the power which forms opinion" fused our differences, and led to agreement about the right way, which many times was not the way by which I had desired to travel. But not with Superintendents of Asylums only, as enlightened and right-hearted men, have I had pleasant and profitable official relations. The bodies of men who direct establishments for the insane, though sometimes opposing the views which I advocated, have yielded me an army of helping friends; and I have drawn them largely also from those concerned in the management of the insane poor who are not in establishments. I say nothing of the insane themselves, except that I know that all of them have had a soft and warm friend in me, and that I believe many of them were able to realise this. To add to their happiness—to improve their well-being—has been the underlying aim of all my work. I have thought it proper to speak first and chiefly of the friendship and happiness that were born of my official relations as a Commissioner in Lunacy; but my other work, which has gone in many directions, has brought me a host of true and helpful friends, many now gone—with grief I say it—but many yet alive. How much I prize these friendships, and the many other friendships not arising out of work of any kind—how much pleasure they have brought, and still bring, into my life my tongue cannot tell. Friendship is called "the wine of life," and with thankfulness I feel to-day that I have been privileged to drink freely of that wine. It has brought me a "solid happiness," and so has helped me on, by giving me whole days for my work, instead of the half days of the unhappy. My official work is now ended. As regards it I have reached old age. But I am not yet conscious of decrepitude, and certainly not of a sad old age. I hope that there is some work still in me, and I mean to do it, though I may to some extent "coil the ropes and take the canvas in." I once thought that I should like to have it said of me, when the very end had come—"He 'lay dead in his harness;" but I am pleased now to feel that I belong to the leisured class, and that I am free to work or to play as I choose. For such work as I have done I have had rich acknowledgments, both from Academies and from the State, and, crowning all, comes the acknowledgment of friendship which I receive to-day. It is "beyond my speaking" to show in words the measure of my gratitude for all the good that has befallen me. Of the portrait, a splendid work of art, I say nothing except that for its flattery I am again a debtor to friendship—to the friendship of the distinguished painter. I am glad that I shall be remembered as I was seen by him, and also by that man of skill from whose hands the engraving comes. I have had to speak of gifts and not of a gift. In addition to the portrait there is a handsome gift to my wife. I cannot tell how much this remembrance of her has gratified us both. She begs me to say that no greater pleasure has ever reached her, and that the kindness to us both has filled her heart with sweetness to the core. The gift to her will take such a shape as will be a perpetual reminder to her of my friends, or rather, as she desires to put it, of my friends and hers. There is a further gift of books to me. Books of value they shall be—books to which, during the days of my life that remain, I shall be always making reference, and from which I shall be constantly drawing enjoyment. Thus in various ways the memory of this day will be kept green in my heart and home.

[We have much pleasure in having secured a photogravure of the mezzotint by Mr. Faed, as inserted in this number of the Journal, and re-echo the kindly wishes of Lord Kinnear for Sir Arthur Mitchell's welfare and happiness.—ED.]

PRESENTATION TO PROFESSOR BENEDIKT.

A very large Committee, representative of Psychiatry in every quarter of the globe, combined to do honour to Professor Benedikt on the occasion of the fortieth anniversary of his literary activity. On the 2nd of February last, at a meeting held in Professor Benedikt's house, his portrait in *alto relievo* was presented with the best wishes of the subscribers. In the evening of the same day a banquet was held at the Grand Hotel, and the distinguished guest of the evening was received with all the honours. Professor Benedikt's many friends in this country (and where can he go without encountering friends?) will on this occasion join most heartily in congratulating him and in wishing him long and happy days in the interests of science and good fellowship.

RESIGNATION OF DR. FLETCHER BEACH.

The resignation of the General Secretaryship by Dr. Fletcher Beach will be learned with regret by every member of the Association. This feeling will, without doubt, find full expression when the question of appointing his successor comes before the Association. In the meantime there arises the difficulty of finding a successor able and willing to undertake the responsible duties which Dr. Beach has so long and so successfully discharged.

HACK TUKE MEMORIAL.

The following subscriptions have been received:—

	£	s.	d.
Dr. Nicolson	3	3	0
Dr. Langdon Down	1	1	0
Dr. J. Hutchinson	2	2	0
Dr. De Watteville	2	2	0
Dr. Batty Tuke	5	5	0
Dr. H. Sutherland	1	1	0
Tuke Mennell, Esq.	2	2	0
Dr. L. A. Weatherly	1	1	0
Dr. J. C. W. Cobbold	1	1	0
Dr. Mickle	3	3	0
Dr. H. Jackson	2	2	0
Dr. Needham	3	3	0
Dr. D. Ferrier	2	2	0
Sir B. W. Richardson	1	1	0
Sir F. Russell Reynolds	2	2	0
Dr. Régis	10		francs

OBITUARY.

LORD BLACKBURN.

The name of the late Lord Blackburn has few recollections of a medico-legal character associated with it. But his lordship once rendered a service to the science of medical jurisprudence which ought not to be forgotten. He was trying a woman on a charge of attempted murder. She clearly knew the difference of right from wrong and the character of her act, and if the judge had charged the jury according to the letter of the answers in McNaghten's case, she would inevitably have been convicted. But Lord Blackburn, to use his own language, "felt it impossible to say that she should be punished," and so he told the jury that while McNaghten's case supplied the general rule, there

were exceptions to it. The jury at once acted on the hint by acquitting the prisoner on the ground of insanity. Many of our judges would not hesitate nowadays to treat the orthodox test of criminal responsibility in mental disease with equal freedom. But Lord Blackburn's "departure" was taken about a quarter of a century ago, when the authority of McNaghten's case was far more unchallenged than it is at the present day.

DR. ROBERT LAWSON.

We regret to have to record the death of Dr. Robert Lawson, Deputy-Commissioner in Lunacy for Scotland, after a valued service of eighteen years in that capacity.

Dr. Lawson was born in Kirriemuir, and, in common with other members of his family, early showed a marked literary capacity. Before entering on the study of medicine, indeed, he had engaged in journalism, and throughout his life he was a devoted student of literature. Dr. Lawson took the degree of M.B. at the University of Edinburgh in 1871, and M.D. in 1888. In his student days he was well known as the maker of witty songs and the retailer of humorous stories, and his kindly, generous nature is fresh in the recollection of many faithful friends. Professor Laycock selected him as his class assistant in 1871-2, and imbued him with the shrewd and original thinking for which the chair of medicine was then celebrated.

After practising for a short time in London, Dr. Lawson became Assistant Medical Officer at the West Riding Asylum, then at the zenith of its fame, under the direction of Sir James Crichton Browne, who valued him as one of the ablest and most agreeable assistants he ever had. His contributions to scientific medicine at that period, particularly his notable research into the "Action of Hyoscyamine," showed that Dr. Lawson combined high literary culture with scientific insight and approved method. For a short time he was Medical Superintendent of Wonford House Asylum, Exeter, from which appointment he was promoted to the onerous and responsible duties which he fulfilled until quite recently. As Deputy-Commissioner, his work led him to the most remote parts of Scotland, where he had to visit and report upon the boarded-out cases of lunacy. Quite recently the writer of these lines heard of a touching instance of his unrecorded kindness in dealing with a somewhat troublesome case, and there can be no doubt that his generous presence will be greatly missed in many a humble home in the far north. In his annual reports Dr. Lawson gave graphic accounts of his journeyings, and strong, unprejudiced support to a mode of lunacy administration which has lately passed under some adverse and ill-informed criticism. His evidence is all the more valuable in having been presented by one who undertook the duties of Deputy-Commissioner after great experience and with a large mind.

His loss is deeply regretted by a wide circle of friends, official and personal—friends who had the advantage of knowing him in private life and recognising that he had it in his power to make a distinguished name. But he was modest and unambitious, and preferred to pursue a quiet bye-path in the great world, illumined by intimate acquaintance with the master minds of literature, and intent upon performing the work he had to do with the kindly care and sympathy of his rich nature.

DR. HENRI CONTAGNE.

The death of Dr. Contagne, the medico-legal expert and lecturer on forensic medicine at Lyons, should not be allowed to pass wholly unrecorded here, since he was always warmly interested in English medical science, and especially in all that concerned the treatment and study of criminals. He was Professor Lacassagne's chief co-worker in the great French medico-legal centre, and his

name came prominently before the public at the time of President Carnot's assassination. He translated Taylor's monumental work, published various medico-legal studies of his own, and was one of the editors of the *Archives d'Anthropologie Criminelle*. He was a charming writer, and wrote several volumes on his travels and on music. He was also an accomplished musician and composer. Almost his last labour was the translation of Dr. Arthur Macdonald's *Le Criminel-Type*, lately noticed in the Journal. His courteous assistance and refined hospitality were always at the service of English visitors, and his death will sever a link between French and English science. He died last autumn at the age of 49.

PARLIAMENTARY INTELLIGENCE.

HOUSE OF COMMONS.

FRIDAY, FEB. 14TH.

Proposed International Commission on Lunacy.

Mr. Kenny asked the Home Secretary whether, in view of the magnitude of the annual increase in the number of lunatics, as shown in the Parliamentary paper issued during the recess, he would take measures to promote an International Commission of Inquiry into the subject of the general increase of insanity, with the object of devising means to arrest its progress.—Sir Matthew White Ridley replied that he had no evidence in his possession to lead him to believe that any practical result would follow the appointment of such a Commission, but he was prepared to receive representations on the subject from the hon. member.

THURSDAY, FEB. 20TH.

Treatment of Lunatics in Ireland.

Mr. Gerald Balfour, Chief Secretary for Ireland, said, in reply to a question, that the subject of the admission and treatment of inmates in workhouses in Ireland engaged his careful attention during the recess in connection with the general question of workhouse administration in Ireland. It was true that in some workhouses harmless epileptics were sent to the lunatic wards, and the Local Government Board often pointed out to guardians that this was not a desirable arrangement. It had been frequently explained in answer to questions in the House that destitute persons of unsound mind were sent to Irish workhouses without either legal warrant or committal, and if unable to take care of themselves they were detained and not allowed to take their discharge. Restraint was only employed in workhouses, as in all civil hospitals, by order of the responsible medical officer, who directed that it should be imposed when he deemed it necessary for the safety of the patient or those about him. The Local Government Board had, however, always advised guardians that when a lunatic in a workhouse was so violent as to require restraint the guardians should endeavour to have him or her committed to the asylum. He might add that the Government had under consideration the introduction of a Bill for facilitating amalgamation of workhouses and for making better provision for certain classes of the destitute poor in Ireland.

Lunacy Statistics.

Sir Matthew White Ridley, answering a question put to him by Mr. Hobhouse, said that the increase in the number of lunatics in England and Wales during the years 1885-93 was 15·5 per cent. and in Ireland 21·8 per cent. The increase in England and Wales during 1893 and 1894 was 2·5 and 2·3 per cent. respectively, and in Ireland during 1894 and 1895 together it was 5·7 per cent. He was not in possession of the figures for Scotland. The question of the causes to which this increase was due had engaged the attention of the Lunacy Boards of all three countries.

MONDAY, MARCH 9TH.

Inveterate Misdemeanants and Inebriates.

The Lord Advocate informed Mr. Pickersgill that the question as to how far the recommendations of the Departmental Committee on Inveterate Misdemeanants and Inebriates can be given effect to is at present engaging the consideration of the Secretary for Scotland in conjunction with the Home Secretary.

TUESDAY, MARCH 10TH.

The Care of Pauper Lunatics.

Mr. Brookfield asked the President of the Local Government Board whether any representations had reached him in favour of extending the Exchequer contribution of 4s. per head in respect of pauper lunatics in county asylums to the maintenance of pauper lunatics returned to workhouse wards after curative treatment, and whether he would carefully consider the feasibility of making the necessary alteration in the law with this object in view.—Mr. Chaplin replied: I have received a large number of communications in favour of a grant being made by the County Councils in respect of certain classes of pauper lunatics maintained in workhouses, and the subject is receiving my consideration.

NOTICES BY THE REGISTRAR.

Examination for the Certificate of Proficiency in Nursing.

Ninety-five candidates applied for admission to the November Examination for this Certificate. Of this number 84 were successful, eight failed to satisfy the Examiners, and three withdrew.

The following is a list of the successful candidates:—

Warwick County Asylum.—*Females*: Harriett Buswell, Ada Cowland, Ruth Coates, Jane Jones, Harriett Kirk, Gertrude Ladbroke, Fanny E. Robbins.

North Riding Asylum, Clifton, York.—*Females*: Angela Brooks, Alice Cooper, Sylvia Large, Elizabeth Yates. *Males*: Charles Best, Ralph Colegrave, Robert Frain, Hogarth John Lord, Walter Over, John Ryan, William Stenning, George White.

Bristol Borough Asylum.—*Females*: Annie Charlotte Flook, Eva Smith. *Male*: Joseph Albert Bryant.

Bethnal House Asylum, London.—*Males*: William Robert Hegerty, Frederick Meek, John Morrison, Alfred William Street, Wilfred Williams.

Coton Hill Asylum, Stafford.—*Females*: Bertha Addison, Sarah Crinean, Mary A. Cartwright, Lizzie Hall, Louisa Smith. *Male*: William Emery.

County Asylum, Stafford.—*Females*: Alice Maud Haimes, Mary A. Brough, Sarah Dunn, Fanny Dukes, Annie Poulston, Theresa Wilson.

St. Luke's Hospital, London.—*Females*: Fanny Sexton, Florence Stuart Zerfass.

Halliford House Asylum, Sunbury.—*Male*: Thomas Burrows.

Moorcroft Asylum, Uxbridge.—*Male*: Alfred Hall.

Argyle and Bute District Asylum.—*Female*: Mary Peters. *Males*: William Rattray, William Allan, Malcolm Haggart.

Burgh Asylum, Paisley.—*Females*: Charlotte Gray, Agnes Krøger, Jessie Paterson. *Males*: Thomas Freebairn, John Mitchell, John D. McLeod.

Perth District Asylum.—*Females*: Margaret Cameron, Grace Munroe, Jane Stuart, Catherine Ward. *Males*: John Fraser, James McKenzie, Robert Stuart.

Roxburgh District Asylum.—*Females*: Alice Keith, Jane Ann McFarlane. *Males*: Charles Henderson, John Thomson.

Stirling District Asylum. — *Females*: Christina Muirhead, Catherine McIntyre, Isa Collinson. *Male*: William John Dalgleish.

Richmond District Asylum, Dublin. — *Males*: Thomas Brennan, Frederick Brunton, Thomas Byrne, William Culverwell, Patrick Joseph Doyle, James Duffy, Joseph Doran, William Delaney, Owen Dolan, Thomas W. Graham, Joseph Hanley, James Langan, Peter Neill, James O'Connell.

Valkenburgh Asylum, South Africa. — *Female*: Annie Jansen. *Male*: Dave Ogilvie.

The following is a list of the questions which appeared on the paper:—

1. Describe fully the skin and its parts: What are its uses?
2. What are the cavities of the trunk, how are they separated from each other, and what do they contain?
3. Describe arterial, venous, and capillary hæmorrhage, and how would you arrest (a) arterial, (b) venous bleeding from the arms and legs?
4. Classify the foods: What digestive fluids aid the absorption of each class of food?
5. What are the rules to be observed in the management of an insane patient known to have heart disease, and subject to attacks of syncope?
6. In what way would you proceed to form an opinion of a person's mental state? Mention the more common forms of insanity?
7. Describe fully the meaning of the atmosphere of a ward being close or stuffy. What do you understand by the proper ventilation of a ward, and how is this ensured?
8. What are the chief causes which induce an insane patient to attempt suicide; and what are the modes of self-destruction usually adopted by (a) males, (b) females?
9. What is an hallucination? Mention the chief forms, and explain why they are so important as symptoms of insanity.
10. What is a bed sore? Is it a preventable disease? Describe fully how you would guard against its formation?
11. In (a) epileptic, (b) paralytic, and (c) senile cases, what dangers might occur, and what precautions should be adopted?
12. Mention the special points to be observed in the bathing of patients.

Three hours allowed to answer this paper.

The questions are valued at 10 marks each: two-thirds of the possible total of marks are required to pass.

The next examination will be held on Monday, the 4th day of May, 1896, and candidates are earnestly requested to send in their schedules duly filled up to the Registrar of the Association not later than Monday, the 6th day of April, 1896, as this is the last day upon which, under the rules, applications for examination can be received.

For further particulars respecting the various examinations of the Association apply to the Registrar (Dr Spence, Burntwood Asylum, near Lichfield), addressing letters in the first instance to 11, Chandos Street, Cavendish Square, London, W.

GASKELL PRIZE AND BRONZE MEDAL.

The next examination for the Certificate and for the Gaskell Prize will take place at Bethlem Hospital in July. Candidates for the Bronze Medal and Prize of ten guineas must send in their essays to the President before 30th May, 1896.

All particulars can be obtained of the Registrar, Dr. Beveridge Spence, Burntwood Asylum, Lichfield.

PAPER SET FOR EXAMINATION FOR THE CERTIFICATE IN
PSYCHOLOGICAL MEDICINE, 19TH DECEMBER, 1895.

1. State Fechner's law: illustrate it by diagrams. State the ratio between stimulus and sensation in the case of light, heat and sound.
2. Describe the condition Pachymeningitis hæmorrhagica interna, and state your views as to its Etiology.
3. What is Cretinism? What is the usual mental condition associated with it? Describe a case.
4. What do you understand by Moral Insanity? Discuss its Medico-legal aspects and describe any case which may have come under your notice.
5. Describe what is meant by Circular Insanity. State prognosis and treatment.
6. Describe the course and treatment of a typical case of Epileptic Insanity. Discuss Larval Epilepsy in its relation to impulsive acts and criminal responsibility.

All the questions to be answered.

DATES OF NEXT MEETINGS OF THE ASSOCIATION.

The next General Meeting will be held on Thursday, May 21st, at the Rooms of the Association, 11, Chandos Street, Cavendish Square, W.

The next Meeting of the Irish Division will be held on Thursday, May 14th, in Dublin.

The Spring Meeting of the South-Western Division is to be held at Bailbrook House, Bath (instead of at Barnwood House, Gloucester, as previously announced), on Tuesday, April 14th. After the business, "The Report of the Committee on Criminal Responsibility" will be discussed, and the Hon. Secretary is to introduce a discussion on "The Nursing Staff in Asylums."

It is expected that the Annual Meeting of the Association will be held on the third Thursday of June, 1896.

CONGRESS AT NANCY.

The Seventh Annual Congress of French-speaking Alienists and Neurologists will be held at Nancy on the 1st August, 1896, under the presidency of M. Pitres, of Bordeaux. Among other subjects will be discussed: (1) The Pathogenesis and Physiology of Hallucinations of Hearing; (2) The Semeiology of Tremblings; (3) The Reception of the Insane into Asylums, in its Therapeutic and Legislative Aspects.

CONGRESS AT MUNICH.

As previously announced, the third International Congress of Psychology will be held at Munich from 4th to 7th August, 1896.

APPOINTMENTS.

DESPARD, Miss R. C., M.B. London, has been appointed Junior Assistant Medical Officer at the Holloway Sanatorium Hospital for the Insane, Virginia Water, *vice* Miss Emily Dove, now Assistant Medical Officer at the London County Asylum, Claybury.

GREENE, THOMAS ADRIAN, Dr., has been appointed Assistant Medical Officer at the District Lunatic Asylum, Ennis.

HARRIS, T., M.D. Lond., has been appointed Visiting Physician to the Manchester Royal Lunatic Asylum.

WATSON, WILLIAM RIDDELL KEMLO, M.A., M.B., C.M. Glasgow, has been appointed Junior Assistant Medical Officer at Devon County Asylum.

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JULY, 1896.

VOL. XLII.

PART I.—ORIGINAL ARTICLES.

*Torquato Tasso and his Biographers.** By W. W. IRELAND,
M.D.

When one compares the few details left us about the life of Shakspeare with the wealth of materials for writing the biography of Tasso we might suppose that there would be little doubt about the main facts in the life of the great Italian poet. Nevertheless some of the most important passages in his life have been the subject of controversy for the last 300 years. These questions especially regarded the treatment Tasso met with from the ducal family of Este, and unless we understand these relations correctly, we may totally misconceive the character of the poet and all the later events of his life. It seems strange that such questions have remained so long undecided; but biographers and critics are often much better acquainted with books and texts and languages than with human nature. A fine illustration of this is furnished by the *Life of Tasso* † by the Rev. Mr. Milman. Here we may refer the reader to a paper in this Journal of January, 1877. The author, whose initials are A. C. M., though his study of the life of Tasso had apparently gone no further than a perusal of Milman's book, was able to show many of the errors into

* Angelo Solerti, "Vita di Torquato Tasso." Turin and Rome, 1895 (3 volumes octavo). "Luigi, Lucrezia e Leonora D' Este, Studi di Guiseppe Campori e Angelo Solerti." Turin, 1888. Angelo Solerti, "Ferrara e la Corte Estense nella seconda metà del Secolo Decimosesto. I Discorsi di Annibale Romei, Gentiluomo Ferrarese." Città di Castello, 1891. "Opere Minore in Versi di Torquato Tasso," Edizione Critica a cura di Angelo Solerti. Bologna, 1891 (2 volumes). Pier de Nolhac e Angelo Solerti, "Il Viaggio in Italia di Enrico III. re di Francia e le Feste a Venezia, Ferrara, Mantova e Torino." Turin, 1890. "Genio e Pazzia in Torquato Tasso." Luigi Roncoroni. Turin, 1896.

† "The Life of Torquato Tasso," by the Rev. R. Milman. London, 1850.

which the biographer had fallen. In truth Mr. Milman, although he took up the traditional view that Tasso was the victim of vindictive persecution by the Machiavelian Duke of Ferrara, yet was too candid to repress a number of facts which, in the eyes of an able psychologist, showed that his whole treatment of the life of Tasso was founded upon a complete misconception or ignorance of the ordinary symptoms of mental derangement.

A previous biographer, by a careful study of the published materials of the poet's life, had come to a correct view of his mental condition. Dr. Black's *Life of Tasso* * is a much superior work to that of Mr. Milman, though it is somewhat too prolix for readers in the present day. Of late years some Italian scholars have made very laborious inquiries into this subject, and the light now thrown upon the events of the poet's life and the different personages with whom he came in contact is so complete and searching that it is impossible any longer to defend the old traditional errors about Tasso which are commemorated in the poem of Byron. Last year, on the three hundredth anniversary of the death of Tasso, Solerti gave to the world his long promised *Vita di Torquato Tasso*, the consummation of his persevering studies, some of the results of which had been given in previous publications. In the first volume of his work, which fills 883 pages, Solerti deals with the life of Tasso. In the second and third volumes, which together make 750 pages, are given Tasso's letters, some of them hitherto unpublished, with other documents about his life and writings, and copies from the portraits and medallions of the poet. There are also engravings of some places rendered memorable by events in his life. An enormous amount of learning and critical skill has been expended in making this work as complete as possible.

Torquato's family can be traced as far back as 1194. They took their name from a hill in the valley of the Brembo which was called Tasso or Taxis from the yew trees which grew abundantly around the tower where they lived for generations. Increasing in wealth and importance they came to a mansion house in the neighbouring town of Bergamo. Solerti gives a genealogical tree of the family, which includes nine generations, down to Bernardo Tasso, the father of Torquato. The Tassi had many members who earned

* "The Life of Torquato Tasso, with an historical and critical account of his writings," by John Black, in 2 volumes. Edinburgh and London, 1810.

renown as generals, diplomatists, and ecclesiastics. Omodeo Tasso had the merit of reviewing the institution of regular posts in the fourteenth century in Italy, France, Germany, Spain, and Flanders. His descendants gained wealth and distinction by becoming generals of the post in these countries. Several branches of the family received titles of nobility from different sovereigns in Europe; and one founded the princely house of Thurn and Taxis. It appears that all the Italian branches of this once vigorous and prosperous family have now become extinct, at least in the male line.

Bernardo Tasso was born at Venice in 1493. He was left an orphan at the age of 18, with two sisters, and it was with difficulty that he could find means to continue his studies at Padua. During the course of an eventful life, changing like a bird from bough to bough, he became secretary to Renée, the daughter of King Louis XII. of France, who was married to the Duke Hercules of Ferrara. This princess favoured the Reformed Religion and corresponded with John Calvin, who spent some months at Ferrara under a feigned name. She afterwards openly avowed her Protestant views, which gave great annoyance to her husband, who held his principality of the Papal See. In the end she was separated from her children and kept for some time in confinement. Bernardo Tasso was employed in important missions as a secretary and diplomatist. As a poet he gained a good reputation in his own day. Becoming secretary to Ferrante Sanseverino, Prince of Salerno, he accompanied the expedition of the Emperor Charles to Tunis in 1535. After a life of toil, dependence, and anxiety, a vision of love and happiness shone on his autumnal days. In 1536 he contracted a marriage with Portia di Rossi, a lady of a noble Neapolitan family who was entitled to a large dowry. They settled at Sorrento on the Bay of Naples. With true Italian frankness Bernardo writes how happily his days went by with his lovely young wife and his little daughter Cornelia. He hoped for a son who would continue the name of Tasso, and he was working at an epic poem, *The Amadigi, or Amadis of Gaul*, which was to secure his memory from the assaults of death and time. A son was born who died in infancy; not long after Bernardo was called away to follow San Severino to the war with France. It was during this war that Torquato was born on the 11th March, 1544. Bernardo was now about fifty years of age.

A month after the birth of this child the French defeated the Imperialists at the battle of Cerisoles. San Severino greatly distinguished himself in conducting the retreat of the Spanish infantry and checking the advance of the French. After this Bernardo visited France and Flanders and did not return to his home till January, 1545, when he first saw his infant son. On his return Bernardo spent two happy years with his wife and children at Salerno. In 1547, Don Pedro de Toledo, the Spanish Viceroy of Naples, attempted to introduce the inquisition into the Italian kingdom, which met with violent opposition. San Severino undertook to lay the case of the recusants before the Emperor Charles, who was then at Nuremberg. In this mission he was seconded by Bernardo. Their representations were not without success; but the Prince found on his return that he had so mortally offended the Viceroy that he could no longer live safely at Naples. Leaving his wife in Naples (1551), Bernardo followed his patron, who went to France, and arranged to support Henry II. in an invasion of Naples. San Severino even went to Constantinople to obtain the help of the Turks, who sent a fleet which ravaged the coast of Calabria and anchored in the Bay of Naples. Bernardo, who took an active part in these negotiations, was declared a rebel, his house was seized, and his property confiscated. He had now to live on what the exiled Prince of Salerno could afford. Apparently the Rossi family had not been on cordial terms with him, and they now took advantage of his discredit with the Neapolitan Government to withhold the payment of their sister's dowry, so that Portia was left in poverty with her two children.

After two years' attendance on the French Court, Bernardo had to abandon the hope of his patron San Severino returning to Naples as the Viceroy under Henry II. He now came back to Italy, in 1554, to resume his wandering and unsettled life. Amongst these cares and afflictions Torquato Tasso attained the age of ten years. He received his first education at a college of the Jesuits, who took care to deepen the religious instruction begun by his pious mother. He says in a letter that "the Jesuit Fathers under whose discipline I was educated, made me communicate when I was about nine years of age, though I was so well grown and my mind showed such signs of maturity that I might have passed for a youth of twelve." In the year 1554 Portia was driven by the persecutions of her relations to seek

refuge with her daughter Cornelia in a nunnery at Naples, and Torquato was sent to meet his father at Rome. In after years he recalled in some pathetic verses how cruel fortune had torn him away from the arms of his tender mother, and the kisses bathed with tears which she gave him at parting. Bernardo was lying ill when his son arrived at Rome. He had the charge of Christopher Tasso, the son of a relative, and the education of the two boys became the object of his anxious care. Befriended by the new Pope, Paul IV., his prospects seemed to improve, and he was providing a home for his wife and daughter when he received news of the death of his wife after a sudden illness of only twenty-four hours' duration. In a letter to a friend Bernardo bewails her death, and accuses himself, through vain ambition and affection to his prince, of leaving her in the power, not of brothers but of enemies, not enemies but pitiless wild beasts, and of a mother not a mother, but to her children a bitter enemy, not a woman, but in sooth an infernal fury. He states his suspicions that Portia was poisoned, and laments the condition of his daughter left in the hands of enemies without a friend save a wretched father, poor, old, distant, and in disgrace with fortune.

In order to keep hold of Portia's dowry her brothers got Torquato declared a rebel, because he had gone at the age of ten to meet his father at Rome. Soon after war broke out between the Pope Paul IV. and Philip II., and the Duke of Alva's advance upon Rome scared away Bernardo, who found refuge with the Duke of Urbino.

The later years of Bernardo's life were passed in Northern Italy, where he was befriended, not only by the Duke of Urbino, but by the Dukes of Mantua and of Ferrara, acting as secretary, diplomatist, or courier, a changeful, toilsome, and difficult life. Dr. Black has suggested that the miseries of need in sight of wealth and splendour, and dependence in sight of power, which the younger Tasso shared with his father, may have laid the foundation of the deep melancholy of his later years. He recalls the observation of Burns about his own frequent depression of spirits. "Extreme sensibility," says the Scottish poet, "irritated and prejudiced on the gloomy side, by a series of misfortunes and disappointments, at that period of my existence when the soul is laying in her cargo of ideas for the voyage of life, is, I believe, the principal cause of this unhappy frame of mind." Nevertheless, although we know

that the younger Tasso sympathised with the fortunes of his father, and there is extant a pathetic letter in which he begs for pecuniary assistance for him, there is a want of proof that those miseries made any abiding impression on his mind. The happiness of young people is not so dependent upon circumstances. The hardships endured by Burns were of a much rougher sort. The bright, handsome, wonderfully precocious boy received much kindness from his father's friends, and shared in many of the luxuries of his father's patrons. If genius increases men's sensibility to pain and disappointment, it also increases the zest of their hopes and enjoyments.

During all his straits and anxieties Bernardo never neglected the education of his son, who was trained by the best instructors in all the learning of the Renaissance. At the age of sixteen he was sent to the University of Padua to study law like Petrarch and Ariosto, and like these poets he neglected that dry study for literature. Going to spend his first vacation with his father at Venice, Torquato gained his consent to return to Padua as a student of philosophy and rhetoric. Bernardo had got his *Amadigi* published in 1560. He had altered many passages in his poem in the hopes of gaining the indulgence of Philip II. of Spain, to whom it was dedicated. This made no impression on that inflexible monarch, nor did the poem meet with the reception which the author hoped for from the Italian patrons of literary merit. Bernardo could not fail to be pleased with his son's verses, though it was said that he never could think them better than his own.

The events of Torquato's life were well adapted to bring his poetical genius to an early bloom. In the short time of ten months he wrote a poem celebrating the exploits of the Paladin Rinaldo. It was published at Venice in 1562, dedicated to the Cardinal Luigi of Ferrara. Torquato, though now only eighteen, was at once recognised as a poet of the first rank. From Padua he was attracted to the ancient University of Bologna, living on a subsidy granted by the Duke of Urbino.

Torquato afterwards wrote that his youth was subjected to the sway of love, and Solerti takes much pains to find out the names of the golden-haired beauties of Lombardy who inspired the sonnets of three hundred years ago.

Tassino, as he was called, was denounced as the author of a pasquinade turning some scholars and professors of the

University into ridicule. Although he denied the authorship, it was thought that, as he could repeat forty or fifty verses of it off by heart, he must have had something to do with the composition of the satire. One witness said that Tassino had not enough of talent to write it. Menaced with arrest he fled from Bologna. In a tirade written against him Tassino was abused as *omni genere vitiorum infamis*, and the less suspicious testimony of two of his cousins leads us to believe that Torquato had taken part in the frolics and dissipation of the wilder students of Bologna.

In 1564 he returned to Padua to continue his studies, and in the following year he entered into the service of the Cardinal Luigi of Este. Torquato, introduced by his father to this illustrious family, had already made a visit to Ferrara, where he had gained friends and fallen in love with one of the ladies of the Court, the beautiful Lucretia di Bendidio. He arrived on the last day of October of 1565, in the midst of the preparations which were being made to give a splendid reception to the Princess Barbara of Austria, who was to become the second wife of the Duke Alfonso II. Tasso was presented by the Cardinal Luigi to his sister the Princess Lucretia. The Princess Leonora was at that time suffering from illness, and he did not see her till later. Their brother, the reigning Duke Alfonso II., now a man of thirty-two years, was endowed with great vigour both of mind and body, reputed a master in war affairs, fond of the society of learned men, a great patron of literature and music. He was of a restless temperament, and in an uneasy position, emulous of rank, jealous and punctilious, and when offended, an implacable enemy. His relations with the literary men whom he attracted to Ferrara were particularly unfortunate. This has injured his reputation with posterity; but every new research seems to remove imputations against his character, which on the whole stands out favourably when compared with other princes of his time. His generosity was kept up at the expense of his subjects, who were heavily taxed while the dykes against the Po were ill kept up; but their complaints were at the time little regarded amidst the brilliant pageantry of the Court.

The poet Guarini had warned Tasso of the corruption of Ferrara, and the insecure life of a courtier; but in those days the favour and patronage of the great were almost the only support by which a man could live if he devoted himself to literature. The Cardinal Luigi appears in Solerti's pages

as pushed when a young man into the Church to hold rich benefices in Italy and France. He was in no way religious, fond of pleasures, given to women, suffering much from gout, often quarrelling with his elder brother, hating trouble and business, a spendthrift, greedy of money, and always in debt. Tasso's duties at Court seem to have been mainly ornamental, writing sonnets and attending the Duke on State occasions. The Cardinal left him ample leisure for writing his poems, in the composition of which he took a lively interest. Lucretia was a woman of vigorous health, fond of pleasures and amusements, ambitious, intriguing and vindictive, the heroine of a drama of adulterous love. The Princess Leonora was always in weak health, never well for three months at a time, suffering apparently from heart disease. She was a woman of spirit, and during the absence of the Duke governed the principality so as to gain the love of the people. From her letters it appears that she was much occupied with the lawsuits of her brother Luigi, whose part she took against Alfonso. Though friendly to Tasso, there is no evidence that Leonora ever regarded the poet with especial favour, and in the end she proved a lukewarm protectress.

Lucretia on the other hand was a true patroness of the arts and poetry, showed a warm admiration for the poet, and evidently came into much closer relations with him. Lucretia was now about thirty years of age, Leonora twenty-eight, and Torquato Tasso was twenty-one. In person his lofty stature distinguished him even amongst tall men;* he was thin but well-proportioned. He had a fair complexion, a high square forehead, brown hair, the beard somewhat lighter, eyebrows finely pencilled, large blue quick eyes, the nose somewhat aquiline, the lips pale and thin, and the teeth white. What strikes us in his portraits is the large portion of the head in front of the ear. The expression was

* The person and appearance of Tasso are described in great detail by his friend Manso; see "*Vita di Torquato Tasso scritta da Gio Battista Manso, Napolitano*," Venice, 1621, p. 236. Solerti reproduces many of his portraits. Some of them, especially those from Bergamo, have little resemblance to the others. It is difficult to get Manso's description to agree with some traits in the portraits. Here are some particulars which are not included in the description above. The head was large and prominent at the base and at the occiput, but in the middle rather depressed at the temples than round. The forehead was large and square. As Tasso got older he lost much of his hair, becoming almost bald. The mouth was rather large, the teeth white, large and thick, and the chin square. There was a looseness in his motions and carriage which disappointed expectation, but his countenance and expression had an air of majesty.

generally grave, he was little inclined to mirth. He was short-sighted, had a slight stammer, and was apt to repeat the last word. Not only was he versed in all the learning of the Universities of his time, and the accomplishments and graces of Courts, but he was skilful in fencing and tilting. Under such distinguished patronage Torquato Tasso entered into this gay and polished Court, in the bloom of youth, yet already a famous poet, seeking honour above all things, fond of distinction, unguarded in his speech, generally temperate in his habits, but a lover of fine wines, seeking the smiles of the ladies of the Court and not in vain.

From Ferrara Torquato was suddenly called to the aid of his father. Worn out with toil and age, Bernardo had left the office of Secretary in Criminal Procedures to the Duke of Mantua for the easier situation of Chief Magistrate of Ostia, a little town on the Po, where he died on the 5th September, 1569, at the age of seventy-six. Bernardo was a strikingly handsome man of a powerful constitution. In his mental activity and his fondness for poetry, as well as his restless disposition, Torquato was the true heir of his father. As Bernardo observed that his son had inherited the talents of his mother, we may conclude that Portia was a woman of superior mental ability as well as of moral worth.

In the autumn of 1570 Tasso went with the retinue of the Cardinal to France, where he spent five months. Anne of Este, Luigi's eldest sister, was the wife of the Duke of Guise. At this time the Protestants were being flattered in preparation for the massacre of St. Bartholomew.

On his return to Italy in the spring of 1571 he quitted the service of the Cardinal. The cause of this change is not certainly known, but at any rate Tasso appeared a gainer, for he now entered the immediate service of the Duke of Ferrara, receiving a much more liberal allowance. Solerti tells us his salary amounted to 15 golden scudi, equal to about 110 lire a month. It appears that this was about the highest pay in the Duke's Court. Guarini, the celebrated poet, did not get half so much. In 1573 he had completed the *Aminta*, a pastoral drama. It was performed at Ferrara, and met with much favour throughout Italy. It shares with *Il Pastor Fido* of Guarini, published twelve years later, the reputation of being the most beautiful composition of the kind in the Italian tongue. Soon after this the Duke gave Tasso the office of Professor of Geometry. The duties were light, for

he had only to lecture on holidays, and the salary, though small, was no doubt a pleasant addition to his income, for the poet, who took little care of money, was generally in debt. He now turned his full attention to the composition of the great epic poem which was to place him by the side of Virgil. Tasso had learned much of the picturesque aspect of things; he had wandered through Italy and France and knew their fairest cities; had conversed with famous warriors and statesmen, and received the changing lessons of adversity and prosperity. Above all, he had the genius to drink inspiration from all sources; what his father had vainly struggled for his more gifted son could easily attain. Caressed by noble ladies, the favourite of a prince, admired as a great poet, holding in his hand the cup of immortality, he seemed to have attained the summit of earthly felicity only to give a pathetic illustration of the vanity of human hopes.

In the August of 1574 Tasso had scarcely finished the last canto of *Jerusalem Delivered* when he was seized with a quartain ague, which lasted for many weeks. In the middle of November he records that he was unable to write a letter with his own hand from languor and weakness. Seven years before he had been ill for a month at Mantua nigh to death, suffering from a fever of some kind which, he noted, weakened his memory for a time. The principality of Ferrara was exposed to the malaria from the overflow of the Po. Intermittent fever sometimes affects the brain, but it can scarcely be a cause of mental derangement save to those predisposed. In Torquato's case there is no record of any hereditary neurosis, but from this illness we may trace a train of symptoms which gradually swelled into significance. In the spring of 1575 he was in better health, and commenced to make journeys to Padua and the neighbouring cities to obtain the opinions of learned men about passages in the *Jerusalem Delivered*. Cantos of the poems were sent here and there to professors of rhetoric, and to divers learned men at Rome, Florence, Venice, and elsewhere. These pundits were much flattered at being consulted by so famous a poet, and returned showers of criticisms, objections, and suggestions. The metaphysicians pointed out how the epic transgressed the rules of Aristotle; the ecclesiastics wished that the love passages should be struck out or frozen down, and scented heresy in the bits about magic and enchanters. Some of them hinted that the Pope would

refuse his license to the poem being printed. Tasso replied to his critics in long letters. Nevertheless he had serious misgivings about the whole plan, doubts about particular passages, and fears about the success of his great poem. The commotion of his mind was increased by anxieties that his manuscripts were lost, and fears that copies were being taken, and that a pirated edition would be printed somewhere. He writes that he was so impatient to see the poem printed that every month's delay seemed a thousand years. "What a wretch I am," he exclaimed; "every one wishes to be my tyrant. I do not refuse advisers if they will content themselves with being merely such." Yet after the first revision, which occupied eight months, the over-fastidious poet set agoing a new one, which lasted ten months, to his own farther vexation.

Tasso had now got tired of Ferrara, and made some overtures, through his friend Scipio Gonzaga, to the Grand Duke of Tuscany. This was calculated to give dire offence to Alfonso, who used to exact a promise from his officials that they would not seek service with another prince without his permission; besides, he especially hated the Medici, with whom he had a long dispute about precedence.

During the summer of 1575 Tasso was again ill, suffering from fever, exhaustion, and confusion in the head. He was distracted by doubts about the existence of God, the creation of the world, the sacraments of the Church, and the authority of the Pope. Though taking some part in the dissipation of a luxurious Court Tasso's mind was deeply religious, not of the kind to keep easily fluttering in scepticism. Distracted with fears of damnation he went to the inquisitor at Bologna and confessed his doubts. Whether such an unusual procedure startled that functionary, or whether Tasso gave other signs of mental aberration, is not known, but the astute priest evidently laid little stress upon the poet's revelations, and Tasso himself thought he did not treat them seriously enough, and was not contented with the absolution granted.

It does not appear that the Duke abated in his kindness to the poet, and Lucretia, now become Duchess of Urbino, had him much in her company. They were both fearful that Tasso would spoil the poem by his changes and corrections, and were desirous that he should publish it at once. The *Jerusalem Delivered* has many passages complimentary to the family of Este and to Alfonso, who wished

his name to be associated with an immortal work. He received offers from the Cardinal de Medici which he would neither accept nor dismiss. He applied to be made historiographer to the family of Este and then regretted when his request was granted. He feared that he could not write a true history without offending some of his patrons. He was in continual dread that his letters were opened and his poems copied, yet he would not desist sending them about all over Italy. In his letters to Gonzaga he bewails his want of resolution, which he fears will prove his ruin. He beseeches his friend to show none of his letters either to a stranger or to any of his family. "Something, I know not what, is whirling through my mind."

The old story that traces all Tasso's misfortunes to his having fallen hopelessly in love with the Princess Leonora, and the deep offence which this gave to her brother, has gained world-wide currency. It forms the theme of Goethe's beautiful drama of *Torquato Tasso*. Some of the verses expressing his first emotions on being presented to the princess are often quoted as showing his unhappy love. They scarcely prove more than the deep admiration which the Court poets of that age were allowed to express in verse for the great ladies whose rank raised them above every other feeling but adoration. As is laid down by Romei, a contemporary writer, "for love to resolve itself into desire it is necessary that the reason should consent to it, but if the beauty resides in too lofty a subject, as in a princess, the hope of union and mutual love being forbidden by the light of reason, the affection dissolves not into amorous desire, but into deep reverence." However, the view that Tasso was really in love with Leonora derives support from the testimony of Manso, his friend and biographer; but if such a feeling existed, it could hardly have been of an engrossing character. So far from there being any proof that Tasso ever nourished a deep and pervading passion, such as Petrarch bore to Laura de Sade, there are many proofs of the fleeting character of his amours. Indeed, he openly proclaims his inconstancies in his verses. "I tried many ladies and found the hearts of many soft to me, but I was hard. I never had a lasting care for a fixed object, and my loves were always inconstant and never burning." According to Serassi,* the author of the first

* "La Vita di Torquato Tasso," scritta dall'Abate Pierantonio Serassi. Roma, 1785.

critical biography of Tasso, who appears as a defender of the house of Este, Leonora was a princess of saintly virtues who kept apart from the vanities of the world, and if there were ever any tender relations between the poet and his patronesses it is much more likely that they were with Lucretia. Serassi tells us that at this time Tasso was only kept from quitting Ferrara by his passion for Eleanora, the young Countess of Scandiano. He celebrates in verse her beautiful lips, which he touched for a moment to find, like Tantalus, deceived—

That nought remains behind the empty kiss
But love's fell poison rankling at the heart.

In another canzone he intimates that if he cannot raise his hopes to gain the love of the Countess, he will not disdain the empire of her waiting maid. We read too of other Leonoras and Lauras. Solerti,* who is exempt from the ordinary weakness of biographers to stand as the indiscriminate advocate of their heroes, mentions some confessions which are not creditable to Tasso as probably owing to incipient insanity. His anxieties were varied by intervals of calm or fits of epicurean gaiety. It seems natural to suppose that a man in Tasso's position should be the object of envy and hatred, and that some of the intrigues and plots which he discovered were so far real as to confirm him in his suspicions. He writes to Gonzaga about a treacherous friend whom he calls Brunello. He had lent this person the key of his chamber when on a visit to Modena, and a report came to his ears that Brunello was seen to enter his quarters during the night accompanied by a locksmith. Tasso succeeded in finding the locksmith, who confessed that he had been to the court to open a door of which the key had been lost. Tasso believed this was to obtain access to a closet in which his secret papers were kept, and guessed that Brunello's design was to make himself acquainted with the strictures on the *Jerusalem Delivered* which had been sent by the various critics with whom he had been corresponding so long.

There are several discordant versions about a quarrel which Tasso got into about this time. The poet had an altercation with a courtier, and this person answering defiantly, Tasso gave him a blow in the face, in the hall of the palace. Soon after the man, with his three

* Vol. i., pp. 247-9.

brothers, set upon Tasso, who defended himself with great prowess till his adversaries fled. Manso, who writes that the rencounter took place beyond the city gate of Ferrara, tells us that the whole four set upon Tasso with drawn swords, and that the poet gained such renown from his brave defence that it passed into a proverb at Ferrara that no one equalled Torquato either with the pen or the sword.* His unworthy adversaries fled to Florence till the affair blew over. Tasso accuses this courtier of opening a chest containing his secret papers, about which he believed every one was interested. He wrote to the Marquis of Monte complaining that during the last eight months he had suffered much, especially from servants, who had stolen many of his precious papers, and though their wickedness was well known to himself and many, it was rather cloaked than punished by the judges. He entreats the Marquis to send him a servant and to threaten and get the Duke of Urbino to threaten him with the severest punishment if he behaved ill. "Tell him," Tasso adds, "that my word will be taken with regard to the propriety or impropriety of his conduct, for judicial proof cannot at this place and in such a case be expected." Eight days after, receiving no reply, he writes another letter repeating this request. By this time the poet had quarrelled with a good many of his critics and literary friends, with Guarini amongst others.

The singularity of the poet's behaviour seems only to have increased the kindness and solicitude of the Duke and his sisters. Lucretia especially did her utmost to calm and divert his anxieties and dissuade him from imprudent steps; but one evening, irritated by the presence of a servant, who was perhaps instructed to watch him, Tasso ran at the man with a knife. This happened on the evening of the 17th June, 1577, as we learn from a letter of Maffeo Veniero, a patrician of Venice and a well-known poet, at that time residing in Ferrara, in which he says: "Tasso was yesterday incarcerated for having in a chamber of the Duchess of Urbino drawn a knife upon a servant; but he has been arrested rather on account of his disorder and in order to have an opportunity to cure him than to get him punished.

* Manso's account ("Vita," p. 73), which seems to me a probable one, is contradicted by Serassi ("Vita del Tasso," Lib. ii., p. 235), who publishes the fragment of a letter from Tasso about the affray. Solerti ("Vita," Vol. i., p. 239) reduces it to an attempt on the brothers to cudgel Tasso. It is, however, clear from the action of the Duke and the flight of the brothers that the affair was of some importance.

He has some strange humours of being guilty of the sin of heresy and of the fear of being poisoned, which I believe arises from melancholic blood confined at the heart and fuming to the brain. A miserable case for one of his worth and goodness."* The Duke was at his country seat of Belriguardo. On learning what had happened he instructed the steward of the palace to tell Tasso plainly that his mind was deranged and that he must submit to medical treatment. He listened to this message with astonishment; but thanked the Duke and promised to obey. Through the friendly hands of the steward Tasso sent a pathetic letter to the Duke asking to be allowed to return to his quarters. Alfonso sent his own physician to attend him. It was thought not safe to let him back to his rooms till bars had been put on the windows, and two men were appointed to watch him. He was allowed to return by the end of the month. He begged that the keepers should withdraw from his room as he could not close an eye while they were there, and this was granted. On the 2nd of July the Princess Leonora came with the doctor to see him, and on the 6th he was sent to Belriguardo.

(To be concluded.)

Statistics dealing with Hereditary Insanity, based on upwards of a Thousand Cases occurring in the Essex County Asylum. By JOHN TURNER, M.B., Senior Assistant Medical Officer.

Fifty years ago Baillarger† showed from a study of 453 cases that insanity is one third more frequently transmitted from the mothers to the children than from the fathers, and that in the case of sons the transmission is as frequently from one parent as from the other, and in the case of daughters the disposition to insanity is inherited twice as frequently from the mother as from the father. Leubuscher‡ apparently referring to some later statistics of Baillarger's dealing with 600 cases, found that:—

1. Insanity on the side of the mother is of more importance from an hereditary point of view than on that of the father; owing to its being more frequently transmitted

* Serassi, "Vita," p. 247.

† "Recherche Stat. sur l'Hérédité de la Folie," *Ann. Med. Psych.*, 1844.

Quoted by Greisinger (*N. Syd. Soc. Transl.*, p. 154).

‡ *Journ. Psych. Med.*, Vol. i, p. 264.

to the offspring generally and often likewise to several children of the same parent.

2. Insanity on the side of the mother is more frequently inherited by daughters, and on the side of the father by sons.

It will be noted that this latter statement does not accord with the second statement of Baillarger's quoted above, but that it is in harmony with Darwin's Law of Heredity.

Dr. Brigham,* of New York, held similar views to Leubuscher as regards the transmission of hereditary insanity in the New World; he found that the mother was a little more liable to transmit insanity to the offspring than the father, and considerably more likely to transmit it to daughters than to sons, while the father more frequently transmitted it to the sons. Thus of 79 men, 42 had insane fathers, 35 insane mothers, and 2 had both parents insane; and of 96 women, 37 had insane fathers, 56 insane mothers, and 3 had both parents insane.

Recent observers on the whole seem to be in accord with these older writers especially regarding the greater liability of the mother to predispose the offspring to insanity, but I have not been able to find any account of later statistics on the subject, apart from a few tables in the annual reports of one or two English and Scottish Asylums showing the degree of relationship of the insane relatives in those admitted with a family history of insanity, and of certain American Asylums which also give tables; but with the exceptions of the reports of the Kankakee and Pennsylvania Asylums, the information given by these American statistics is vague, the degree of relationship not being stated, and only in some cases is it stated whether the predisposition to insanity is on the paternal or maternal side. There are, I think, very strong objections to the publishing of annual tables in asylum reports concerning hereditary predisposition to insanity in the cases admitted during the year, as, unless elaborate precautions are taken, relapsed cases in which where there is an insane heritage it is very usual for temporary improvement to occur, are liable to be included more than once in successive tables. And further I have found here not at all unfrequently that, although on admission no family history of insanity could be elicited, that subsequently, perhaps many months after, such information was obtained from visitors or friends, and many of such

* *Journ. Psych. Med.*, Vol. i., p. 91.

cases would fail to be included in any yearly table dealing with admissions only. For these and other reasons it is much better to publish the results obtained from a large number of cases extending over many years, as in this way with a little care it is easy to prevent including the same individual more than once, and one is more likely to obtain all the information possible concerning each case.

Dr. Clouston's* impression is that states of depression of mind are hereditary more than most morbid mental symptoms. An hereditary predisposition to insanity was admitted in about 30 per cent. of the cases of melancholia sent to Morningside, but he thinks this is very far from representing the entire truth. So far as my figures go they support this belief. During the last ten years the proportion of cases of all forms of mania admitted to all forms of melancholia has been amongst the males in the ratio of 3 to 1, and amongst the females 3·4 to 1. In those admitted during the same period with an hereditary predisposition to insanity the ratio of all cases of mania to melancholia was amongst the males 2 to 1, and amongst the females 1·7 to 1.

Dr. Campbell† believes that "hereditary predisposition from the maternal side is more baneful than from the paternal, that the predisposition derived from melancholia states with suicidal tendencies is a more transmissible insane element than the nerve flaws which result in cases of mere excitement, and that the unknown condition which produces epileptic insanity is of all others one of the most dangerous legacies."

The figures on which I shall base my conclusions consist of 1,039 individuals with hereditary predisposition to insanity, who have been admitted into this asylum during the last ten or eleven years; but in the first place I shall refer to the American tables which deal with very large numbers in order to discover how far they agree with the figures of this asylum.

It is only the Pennsylvania Asylums which give in their tables the number of fathers and mothers insane. In the last report to hand, September 1894, 129 male residents with hereditary predisposition had the father insane in 56 instances, the mother in 60, and both parents in 13. 149 females with hereditary predisposition had the father insane

* *Lectures on Mental Diseases*, 3rd edition, p. 119.

† Cumberland and Westmorland Asylum Report, 1890.

in 69 instances, the mother in 77, and both parents in 3. The total number of insane mothers was 137, and fathers 125. In the tables for 1891 dealing with residents, and therefore including many of the above, the figures were as follows:—Of 121 males 35 had insane fathers and 69 insane mothers (the insane mothers practically twice as numerous as insane fathers). Of 158 females 53 had insane fathers, and 98 insane mothers. The total number of insane mothers was 191 and fathers 112. That is to say the mothers were more frequently the transmitters of insanity to the offspring in the ratio of 1·7 to 1.

Now with reference to relatives on the maternal or paternal side; the Pennsylvania, Willard State, and Kankakee (Eastern Hospital) Asylums all agree in having more inmates with maternal relatives insane both amongst the males and females. In the Buffalo Hospital and the New York State Hospitals the order is reversed.

When these figures* are added together we find that 687 males had 311 paternal and 376 maternal relatives, and that 711 females had 316 paternal and 395 maternal relatives; and they bear out the statement that the mother is more liable to insanity than the father, and is more liable to transmit this predisposition to her female offspring and more remote descendants.

The Kankakee Hospital gives some figures relating to a family history of intemperance in alcohol in the insane, and, as might be expected, such a condition is met with much more frequently on the paternal side, rather more than ten times as often according to these figures, and the male relatives are affected rather more than twice as often as the females.

So far as I know, the only English Asylums which publish tables concerning hereditary predisposition to insanity are the Cumberland and Westmorland, the Derby Borough, and the City of London Asylum. The results from these asylums (for five years 1889 to 1893 Derby, 1888 to 1892 Cumberland and Westmorland, and for six years 1888 to 1893 City of London) represent 484 individuals with hereditary predisposition admitted during this series of years, but being yearly tables it is very probable that the same individual is included more than once in some cases.

* Referring to Pennsylvania Asylums Report, 1894. Kankakee Eastern Hospital, 1892. Buffalo State Hospital, 1891. Willard State Hospital, 1892. New York State, 1894.

In the Derby Borough Asylum the males have rather more insane fathers than mothers, but the difference is too slight to be of much significance (11 to 10); the females rather more insane mothers (13 to 9). As regards paternal or maternal relatives, including parents, the males have 21 of the former to 17 of the latter; the females 19 paternal and 27 maternal relatives. In the Cumberland and Westmorland Asylum the figures are as follows:—The males, 24 fathers and 23 mothers; the females, 18 fathers and 21 mothers. The males have 42 paternal relatives and 31 maternal relatives insane. The females have 33 paternal relatives and 30 maternal. In the City of London Asylum the numbers of fathers and mothers insane, amongst the males, is equal, viz., 14. The females have five fathers insane and four mothers. The males have 22 paternal relatives insane and 20 maternal; the females 12 paternal and 11 maternal. The totals for these three asylums show that the mothers are slightly more numerous than the fathers (85 to 81); that the males have more (2) fathers insane than mothers, and the females more (6) mothers insane. The males have 85 paternal relatives and 68 maternal. The females have 64 paternal and 68 maternal.

These figures are in accord with Darwin's Law of Heredity that adult paternal characteristics are more liable to be transmitted to male offspring and adult maternal characteristics to female offspring, but the difference is too slight to have much significance, more especially, as we have already seen, they are contrary to the results obtained when dealing with large numbers in American Asylums. They are, it is true, in agreement as regards direct and reversional transmission with my figures, but here again there is too slight a difference to attach much importance to the fact.

I will now proceed to examine my tables.

No. I. not only gives the degree of kinship, but the actual number of insane relatives of each degree of kinship so far as could be ascertained. In the last column the figures are reduced to percentages for the purpose of comparison between the males and females.

This table brings out in a very striking manner the greater influence the mother and the maternal relatives have in the transmission of insanity to the offspring and more remote descendants. It shows the preponderance of mothers to fathers (240 to 197), of maternal grandparents to paternal (55 to 37), of maternal uncles or aunts to paternal (151 to

110). The cousins form the only exception, there being rather more paternal cousins (cousins on the father's side) than maternal. The last column enables the males and females to be compared, and shows that there are rather more females with insane parents, drunken parents, insane grandparents, and uncles and aunts. Taking the reversional and collateral relatives (excluding brothers and sisters) we find that 100 insane males have 58 insane relatives on the mother's side and only 42 on the father's, and a hundred insane females exactly the same, 58 of mothers' relatives to 42 of fathers.

I have mentioned above that in the case of the direct and reversional relatives the males have a slight excess of paternal relatives over maternal, *e.g.*, 91 fathers to 85 mothers, and 18 paternal grandparents to 15 maternal; but it is impossible, in dealing with so large a number, to attach much importance to so slight a difference.

I have also collected 123 instances in which one or both parents of insane children were drunkards. As would be expected the fathers predominate, but not to such a marked extent as in the American tables, where they are as ten to one, while in my cases they are only as four to one. My figures, however, show a rather greater number of insane females with drunken parents than males, but the American tables show rather more than twice as many males as females.

Table No. II. refers to the offspring of the fathers and mothers in Table No. I. It shows how many (as far as could be ascertained) insane children each father and mother had. This is information which can generally be obtained with a fair amount of accuracy from the friends or relatives in cases where a predisposition to insanity in the family is admitted. 186 fathers are tabulated, their insane offspring numbered 255. Nearly 71 per cent. had only one child insane, 29 per cent. had more than one. Reduced to percentages for purposes of comparison it will be seen that 100 insane fathers had 137 insane children, of whom the females were slightly in the majority.

236 mothers had 303 insane offspring. There is a much greater preponderance of females in this class (1.6 to 1). 80 per cent. of the mothers had only one child insane, the other 20 per cent. had more than one. The number of insane offspring is rather lower in the case of the mother being insane than the father. Thus 100 insane mothers had 128 insane offspring.

When both parents are insane their insane offspring are relatively much more numerous, being in the proportion of 178 to every 100 insane couple. In this class no less than 43 per cent. had more than one child insane, but the two sexes are fairly equally affected, there being of the 50 children 21 sons and 29 daughters.

This table shows in a very decided manner that whichever parent is affected, or if both parents are, that in all cases the evil influence is more marked in the female offspring than in the male. These results do not refer entirely to certifiable insanity, but include also cases of mental feebleness which have not required asylum treatment.

The facts brought out by these tables are, with the trivial exceptions above noted, not in accord with the Darwinian Law of Heredity. They do not show that paternal adult characteristics are transmitted to their male offspring rather than to their female offspring. Nor do they support the view held by some that the law of mental heredity crosses the sexes, the mother transmitting her characteristics to the sons and the father to the daughters. I see no adequate reason why there should be an agreement in the case of certifiable insanity with either of these laws, if we only bear in mind that it is not insanity itself which is transmitted from the parent to the child, but merely a more or less unstable condition of the nervous system, which either gives out on the first shock of birth or later on. These latter, who acquire insanity later on in the course of their life, have, so to speak, a jerry-built brain, perhaps capable of steering its possessor safely along the paths of life, while they are easy and smooth, and no undue obstructions or difficulties arise, but quite inadequate to withstand any severe stress or shock, such as it is probable those who actually fall victims to their hereditary weakness have encountered. Thus many male offspring of insane parents, although they have inherited an unstable nervous system, will, whilst their affairs go easily with them and they are not addicted to pernicious excesses of a sexual, alcoholic or other nature, be enabled to play their rôle in life creditably, or at any rate to steer clear of the lunatic asylum. The female offspring of insane parents are, however, exposed necessarily from their sexual peculiarities to greater stresses than their brothers. The periods of puberty, child-bearing, and the climacteric are associated in them with such grave disturbances of the system generally that they must possess an ordinarily healthy nervous system

to withstand the stress laid upon them at these times, and as every female has to pass through at least two, and many through all these crises, it is not surprising that with ill-developed, ill-nourished, and unstable nervous systems, few escape from breaking down at some period of their life.

Doubtless, if we could gauge degrees of stupidity with sufficient accuracy, and had the material tabulated, it would be found that silly fathers had more silly sons, and mothers daughters, or *vice versa*, in conformity with one of the laws mentioned above, but the exceedingly rough test of certifiable insanity does not permit of such delicate analysis. At best it gives us a rough guide to those individuals who have most largely inherited their parental or ancestral weakness: to those that is whose nervous system has broken down so far as to necessitate asylum residence for their care.

That this explanation accounts for the large number of females affected with hereditary insanity in proportion to males is rendered probable by the results obtained from some statistics dealing exclusively with congenital cases in whom one or other or both parents have manifested insanity, to which I shall now refer.

Table No. III. deals with congenital cases, and also cases of adolescent insanity, in which frequent relapses indicated highly unstable nervous systems or else in which some one or more physical stigma (such as narrow, badly-shaped palate) existed, indicated an ill-developed brain. The numbers of parents insane with imbecile offspring are 151 and the number of children 188. Sixty-five insane mothers had 76 imbecile children and fifty-four insane fathers had 72, and in 16 cases where both parents were insane there were 40 children imbecile.

Raised to 100 for purposes of comparison, it will be seen that—

100 mothers had 117 imbecile offspring.

100 fathers had 133 imbecile offspring.

100 both parents insane had 250 imbecile offspring.

The results obtained from this table are strictly in accordance with the Darwinian Law of Heredity. They show that the mother is more liable to transmit her unstable nervous system to her daughters and that the father is more likely to transmit it to his sons.

TABLE No. I.

	Males.	Females.	Total.	Percentages.	
				Males.	Females.
I. Direct —					
Both parents insane... ..	11	21	32	2·6	3·3
Father	91	106	197	21·7	17·0
Mother	85	155	240	20·5	24·8
II. Family History of Intemperance —					
Both parents drunkards	3	9	12	0·7	1·4
Father drunkard	36	53	89	8·6	8·4
Mother	7	15	22	1·6	2·4
III. Reversional —					
Father's father	8	9	17	1·9	1·4
„ mother	9	11	20	2·1	1·7
„ grandfather	1	1	2	—	—
„ grandmother	—	—	—	—	—
Mother's father	7	17	24	1·6	1·7
„ mother	6	25	31	1·4	4·0
„ grandfather	1	1	2	—	—
„ grandmother	1	1	2	—	—
IV. Collateral —					
Brothers... .. .	107	108	215	25·8	17·2
Sisters	79	80	259	19·0	28·8
Father's brother	24	33	57	5·7	5·2
„ sister... .. .	14	39	53	3·3	6·2
„ uncle... .. .	—	2	2	—	—
„ aunt	—	2	2	—	—
Mother's brother	31	38	69	7·4	6·0
„ sister	25	57	82	6·0	9·1
„ uncle	5	6	11	1·2	0·9
„ aunt... .. .	2	3	5	—	—
First cousin on father's side ..	11	26	37	2·6	4·1
„ „ „ mother's side ..	14	18	32	3·3	2·8
Sister's children	1	3	4	—	—
Brother's children	—	2	2	—	—
V. H. P. not defined —					
Father's side	2	2	4	—	—
Mother's side	2	6	8	—	—
Number of Individuals	414	625	1039	—	—

TABLE NO. II.—Showing in the case of insane parents the number and sex of the insane offspring.

186 Fathers in- sane ...	{	1 child insane ...	132=70·9 %	{	sons ...	56	{	Sons ... 117
		2 children insane	41=22·0 "	{	daughters ...	76		
		3 " "	11=6 "	{	sons ...	42		
		4 " "	2=1·07 "	{	daughters ...	40		
	{	1 child insane ...	188=80 "	{	sons ...	14		Daughters 138
		2 children insane	37=15·6 "	{	daughters ...	19		
		3 " "	8=3·3 "	{	sons ...	5		
		4 " "	1	{	daughters ...	3		
236 Mothers in- sane ...	{	1 child insane ...	16=57 %	{	sons ...	64	{	Sons ... 113
		2 children insane	7=25 "	{	daughters ...	124		
		3 " "	2=7·1 "	{	sons ...	31		
		4 " "	2=7·1 "	{	daughters ...	43		
	{	1 child insane ...	16=57 %	{	sons ...	13		Daughters 182
		2 children insane	7=25 "	{	daughters ...	11		
		3 " "	1	{	sons ...	3		
		4 " "	1	{	daughters ...	1		
28 Both parents insane ...	{	1 child insane ...	16=57 %	{	sons ...	2	{	Sex not stated... 8
		2 children insane	7=25 "	{	daughters ...	3		
		3 " "	2=7·1 "	{	sons ...	2		
		4 " "	2=7·1 "	{	daughters ...	3		
	{	1 child insane ...	16=57 %	{	sons ...	7		Total ... 303
		2 children insane	7=25 "	{	daughters ...	9		
		3 " "	2=7·1 "	{	sons ...	2		
		4 " "	2=7·1 "	{	daughters ...	12		
28 Both parents insane ...	{	1 child insane ...	16=57 %	{	sons ...	5	{	Sons ... 21
		2 children insane	7=25 "	{	daughters ...	1		
		3 " "	2=7·1 "	{	sons ...	4		
		4 " "	2=7·1 "	{	daughters ...	4		
	{	1 child insane ...	16=57 %	{	sons ...	3		Daughters 29
		2 children insane	7=25 "	{	daughters ...	4		
		3 " "	2=7·1 "	{	sons ...	3		
		4 " "	2=7·1 "	{	daughters ...	3		

TABLE NO. III.—Showing in the case of insane and alcoholic parents the number and sex of the offspring who were either congenital imbeciles or the subjects of adolescent insanity with congenital defect.

	Mother.				Father.				Both Parents.			
	Insane.		Alcoholic.		Insane.		Alcoholic.		Insane.		Alcoholic.	
	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.
1 Child ...	18	37	3	5	24	14	10	15	4	3	1	2
2 Children	9	9	—	—	18	10	1	1	—	4	—	—
3 „ ...	1	2	—	—	4	2	—	—	4	2	—	—
4 „ ...	—	—	—	—	—	—	—	—	4	8	—	—
5 „ ...	—	—	—	—	—	—	—	—	2	3	—	—
6 „ ...	—	—	—	—	—	—	—	—	3	3	—	—
Total ...	28	48	3	5	46	26	11	16	17	23	1	2
No. of parents }	65		8		54		26		16		3	

Summary.

Direct inheritance.—(a) Taking all classes of insanity, acquired and congenital, we find that whilst the insane father transmits his mental instability to a greater number of offspring than the insane mother, it is on the daughters that it mostly falls, and where the mother is insane the influence is still more marked in the direction of the daughters; so that whichever parent is insane, more daughters ultimately become insane than sons.

(β) The number of insane mothers is very considerably greater than insane fathers.

Reversional and collateral inheritance.—(a) In both sexes the stronger hereditary influence comes through the maternal branch of the family.

(β) The males have the larger number of brothers insane, the females the larger number of sisters.

Bearing in mind the suggestions previously advanced as to the greater amount of stress that the female is physiologically exposed to, I am inclined to think that the results arrived at in Table III. give us a correct idea concerning the transmission of mental instability.

In this series extraneous circumstances have been excluded to a large extent, and the results are in harmony with Darwin's Law of Heredity. But larger numbers will have to be dealt with before any positive conclusion can be arrived at. Where we deal with all classes, as in Table I., these results are liable to be masked to a certain extent by other causes already mentioned. If such be the case the discrepancy between the two tables will serve to give us an idea of the marked influence that extraneous circumstances have in determining actual insanity in those predisposed to it.

*Certain Conditions of the Circulatory System in the Insane.**

By SAMUEL EDGERLEY, M.A., M.B., Assistant Medical Officer, Roxburgh District Asylum.

I propose to-day to discuss certain conditions of the circulatory system of the insane which are of interest clinically, and which have been illustrated by cases seen by me recently.

The connection between the mind and the circulatory system is an exceedingly close one. The effect of such mental emotions as fear and shame in producing pallor and blushing through the vaso-motor and vaso-dilator mechanism is a matter of common experience, while conversely all are acquainted with the pleasurable mental states produced by the increased flow of blood through the brain during normal physical exercise or under other stimulus, and with the contrary condition of the mind existing in the lethargy and languor caused by a sluggish circulation.

When we consider pathological states, we find the connection quite as marked, to take for example the fear of impending death, which is such a frequent and painful feature of the paroxysms of angina pectoris.

Mental disease brings out quite as fully the relation between the two. The signs of enfeebled circulation and its effects upon the other bodily organs are well shown in demented, while amongst the most constant morbid appearances found in the brain post-mortem are the naked-eye and microscopic changes in and around the vessel walls, and the irregular hyperæmic and anæmic areas which give evidence of altered circulatory conditions during life.

* Read at the Glasgow Meeting of the Medico-Psychological Association, 12th March, 1896.

We find that a large proportion of the patients on admission into asylums show signs of heart disease and circulatory abnormalities of all kinds. In the *Journal of Mental Science* recently, Dr. Beadles gave the percentage of patients with heart disease admitted into different asylums as varying from six to twelve. The percentage of those admitted into the Roxburgh District Asylum who present physical signs of heart disease is considerably higher, viz., nineteen. This includes not merely cases of valvular disease, but those in which there was good reason to diagnose degenerative lesions. This high figure may partly be due to the fact that we have not, as in larger city asylums, so many patients admitted suffering from the temporary effects of the distractions of a city life, in whom the mental conditions are apt to be more fleeting, and who are at an earlier period of life and less likely to suffer from cardiac disease. Comparison with post-mortem records, however, corroborates the figure mentioned, and Dr. Beadles states that on post-mortem examination no less than 91 per cent. showed structural disease of the valves or muscular substance of the heart.

The statistics already given refer to patients with organic disease, but an additional number of patients are found to present such modifications of the heart sounds as impurities, alterations in tone or pitch, accentuations, and reduplications, which may be referred to such dynamical causes as erratic or deficient cardiac innervation, want of muscular tone, and alterations in pressure in the vascular system. A very good instance of how such modifications may readily be produced, even in persons perfectly sound both mentally and physically, is afforded by the blowing murmur audible over the aortic arch in certain persons under the influence of vigorous bodily exercise or strong mental emotion, conditions which are present in a marked degree in those labouring under insane excitement. The percentage of admissions presenting these modifications of the heart sounds was seventeen. In none of these was there any reason to suspect organic disease of the heart, but in some the murmurs which were audible at the base were evidently due to anæmia.

That such altered conditions of the circulatory system, organic and functional, form an unfavourable element in prognosis regarding the mental disease under which the patients labour, is fully borne out by such statistics as I have been able to collect, as well as by a study of the patient's malady in individual cases.

The percentage of recoveries amongst those of the three hundred or more patients whose heart sounds were found to be pure on auscultation was forty-four. Among the unrecovered are general paralytics, imbeciles, and other unfavourable cases. The percentage of recoveries (*i.e.*, from their mental affection) of those who had organic disease of the heart or vessels was twenty-seven, while of those who showed decided auscultatory evidence of functional disorder of the circulatory system only 26 per cent. recovered, and a large proportion of these were cases in which the mental unsoundness was associated with anæmia, and in which the murmurs present on admission disappeared on treatment concurrently with the improvement in the general health of the patient.

Although the recovery rate in the two latter classes is thus very similar there is a marked difference in the death rate. Of those who suffered from organic disease, up to the present 24 per cent. have died, while of those who suffered from functional disorder of the circulation only $4\frac{1}{2}$ per cent. have died. This would seem to show that while the bodily functions can all be tolerably well performed, and a fair measure of physical health preserved with this impaired circulation, the mental disorder is not more likely to be recovered from than if more marked morbid structural change were present. Indeed this is just what we might expect from a consideration of the peculiar and special connection existing between the cortical tissue and its vascular supply, in that for the proper performance of its functions the former makes very varying and sudden demands upon the latter. As Sir Wm. Broadbent remarks in his Croonian Lectures on the Pulse, "The functional activity and efficiency of the brain are even more dependent upon the blood supply than its nutrition . . . so that blood which would maintain the structural integrity of the brain might be altogether unfit to minister to its functions."

Various trains of symptoms have been described as associated in the insane with the different forms of valvular disease, but these symptoms appear to have a closer connection with the extent to which compensation has failed. Sane persons suffering from cardiac disease frequently show a certain amount of irritability, despondency, and lack of spontaneity, with hypochondriacal ideas, and these features we find exaggerated in the insane who happen to be similarly affected physically.

Where the cardiac lesion is not very marked, and where there is no distinct failure of compensation, and the other bodily organs have not begun to suffer to any extent, *e.g.*, in some cases of obstructive disease, aortic or mitral, the mental symptoms are such as we might expect to find in connection with an anæmic and badly-nourished brain, and resemble somewhat those present in phthisical and other forms of insanity associated with malnutrition. There is a certain amount of depression present, accompanied by general irritability, sullenness, and suspicion, the patient imagining that he is ill-treated, that plots are being laid against him, and that he is being robbed or poisoned. The various painful and uncomfortable sensations which happen to be present may form the basis of somatic delusions. In cases where there is less compensation, and in rather more serious forms of valvular disease, such as mitral regurgitation, where the physical condition of the patient is more impaired, and he is less inclined for effort, we find similar mental symptoms, but the delusions of suspicion are less likely to find outlet in outbursts of excitement than to lead to a general feeling of resentment against all and sundry.

In the earlier stages of failure of compensation from aortic regurgitation, that form of valvular disease in which the blood supply of the brain soonest becomes deficient, as evidenced by the attacks of faintness and syncope, we often meet with a mental condition similar to that produced by a diminished supply of blood from other causes, such as severe hæmorrhage, in which the brain cells for a time exhibit excitation of function, the patient showing great restlessness, often talking and shouting, interfering with others, and completely losing his self-control. In more advanced cases the patient loses all sense of his surroundings, and becomes delirious, this being in many cases the precursor of death. Sir Wm. Broadbent states that in his opinion a minor degree of the disturbing influence which causes convulsions, causes maniacal delirium, and he instances their occurrence in uræmia and brain syphilis. This is probably similar to what occurs in aortic incompetence, where a more slowly established and less severe degree of anæmia of the brain produces mania and maniacal delirium, instead of the convulsions of severe hæmorrhage, or of the last stages of aortic incompetence itself.

In all cases, however, where the mental symptoms are due to a distinct and later stage of failure of compensation in

the circulatory system, whatever be the original form of cardiac disease—a condition likely to occur earlier in aortic incompetence, owing to the fact, probably, that no amount of hypertrophy of the left ventricle can keep the arteries sufficiently filled—we have to take into account also the retarded venous return, leading to a stasis of the blood current in the brain. Here the mental symptoms are those caused in addition by the presence of impure blood, which not only fails to afford suitable nutriment for the cells, but actually supplies poisonous matter. Such an increase of backward pressure, acting upon vessels which in these cases are apt to be degenerated, would seem to account for the various forms of recent apoplexies often found after death. The following case exhibited typical symptoms during life, and, post-mortem, innumerable minute apoplexies scattered throughout the brain.

(1.) On admission the patient was sixty-three years of age, and had exhibited signs of mental deterioration for about three years.

His first symptoms were loss of memory and inattention to work, leading to pecuniary loss and enforced retirement from business.

With increasing impairment of memory he began to harbour delusions of suspicion against his wife and family. He thought that they were robbing and trying to poison him, and frequently this led to his refusing food. He complained of vague pains in the head, and his physical health deteriorated greatly. During the month preceding his admission he had become much feebler, and his mental symptoms had increased.

He was now very restless and obstinate, threatened violence to his relatives, refused his food, and was altogether unmanageable.

When admitted he was in a very feeble state. Examination revealed aortic obstruction and incompetence with dilatation. The cardiac action was hurried and feeble, compensation had evidently failed, and his vessels were atheromatous.

In spite of his extremely debilitated state he could not be kept at rest, but was continually groping about, plucking at his clothing, clutching bystanders, and murmuring in an incoherent way. It was impossible to gain his attention for more than a few seconds at a time, and no intelligible information could be extracted from him.

For the first few days after admission he showed marked motor restlessness, though he was hardly able to stand, and usually fell back into bed when he attempted to leave it. He appeared to suffer from a vague sense of uneasiness and to be endeavouring to escape from some haunting fear. After this he became too feeble to move about, and died one week after admission.

At the post-mortem examination a remarkable number of small hæmorrhages were found in the brain in every direction. The great majority were about the size of a small pin's head, but a few were somewhat larger. They were most numerous in the right temporo-sphenoidal lobe.

Numerous engorged vessels were noted, and several small intensely congested areas. The circle of Willis was atheromatous, but that condition was not specially evident in other vessels, though there was ample microscopical evidence of disease.

The heart was hypertrophied, the aortic orifice narrowed, and the valves thickened, incompetent, and covered with nodules. This patient before admission had shown mental symptoms commonly associated with cardiac disease, advancing with the gradual failure of compensation. The last few days of his life showed the effects of cyanosis and marked backward pressure, which eventually led to the giving way within a short period of time of innumerable small vessels, and caused the motor restlessness followed by impairment.

So far we have been considering cases in which the mental symptoms depended on defects in the circulation, but while such defect is only one of the many causes of insanity, we have the converse occurring to an even greater degree, and find mental disease producing marked alterations in the circulatory system, both organic and functional. The effect of increased activity of the cortical cells in producing a rapid flow of blood through the brain is well known, and where, as in some forms of insanity, this activity is exaggerated and prolonged beyond normal limits, it is not surprising that the general circulation should show some modification, especially as the cardiac and vaso-motor centres are sure to be disturbed by the abnormal processes going on in the cortex, whilst also in many cases we have to take into account the excessive physical exertions. It is a matter of common experience that when the brain cells are recovering from the storm through which they have passed the circulation readapts itself to the physiological conditions. This must occur before health can be restored. In other cases, however, it undoubtedly happens that the brain is unable to regain this command of the circulation, a pathological condition has been established, and such a condition, even though slight in degree, militates strongly against the mental recovery. Is not this the reason why hæmatoma auris is usually regarded of such unfavourable import in the prognosis of insanity, simply because it indicates grave dis-

turbances in certain branches of those vessels which supply the brain? The cases to which I have referred as exhibiting on admission signs of dynamical cardiac disturbance, with a comparatively low mental recovery rate, afford proof of the serious result of this loss of balance between the cortex and its blood supply. If we take, for instance, cases in which the heart sounds were found to be impure, we know that such impurities often indicate conditions which in course of time may give rise to actual murmurs, and doubtless this is why such a very large proportion of hearts examined post-mortem in asylums show signs of organic change, while a much smaller number of patients on admission are diagnosed as having heart disease. In fact, in the case of patients suffering from frequent attacks of excitement, we can often note these impurities giving place to actual murmurs. In recent insanity we often see the process going on with more or less rapidity, as, for instance, in acute delirious mania, where heart failure so often supervenes. This may occur with the greatest suddenness, and in cases in which there is already some organic disease of the heart, though perhaps not advanced, no great motor excitement is required to bring about a fatal issue.

This was well illustrated in the case of an early general paralytic who died suddenly in Melrose Asylum.

(2.) On admission there was a murmur of aortic obstruction, but the pulse was regular and full, and there appeared to be no marked impairment of circulation. Compensation seemed to be fully established. His mental condition was one of great exaltation.

Though for the first two days after admission he was rather restless and moved about his room a good deal at night, after that his chief physical exertion was talking and singing. Out of doors he lay among the hay sunning himself, boasting of his powers. This mental excitement eventually told upon him, and one morning nineteen days after admission he complained of feeling faint, and notwithstanding appropriate treatment he died in less than half an hour.

In some cases of acute excitement, when the patient is at or beyond middle life, it is evident that sudden dilatation of the heart occurs, and the condition is one of great gravity, threatening the patient's life for the time being and his mental recovery in the future.

(3.) An example of this was afforded by a female patient aged 46, who was admitted labouring under acute mania, and in whom the mental symptoms had only existed for about a fortnight. Her

cardiac action was rapid and slightly irregular. Her mental condition was one of great excitement. She was quite incoherent, her attention could not be commanded, and she continued to run about, shouting and singing. When exhausted, she would sit or lie down with her eyes closed and an expression of rapture on her face, muttering prayers for strength and guidance, and then shortly resume her excitement. She got regular outdoor exercise, and when within doors endeavours were made to get her to lie down as much as possible. She continued in much the same condition for about a fortnight, when she suddenly collapsed, lying motionless, uttering no sound, and wearing a look of extreme distress and anxiety. Her pulse was feeble, short and fluttering, and ranged from 130 to 150 per minute; the respiration was sighing, and dilatation of the heart was found to have occurred, with the development of a mitral systolic murmur.

She remained in this serious condition for four days, when, having gradually renewed her vigour under treatment by rest, strophanthus, and suitable diet, she again became excited, left her bed, and resumed her previous condition. This lasted for about ten days, when threatened cardiac failure again occurred, accompanied by œdema of the legs and feet, the conditions being less serious than formerly. Though she remained in bed, she gave evidence of being very delusional and incoherent.

From this time her physical condition gradually improved, but though she became less noisy she showed no other improvement mentally. The circulatory system had evidently become permanently impaired, and a hæmatoma occurred in the right ear less than two months from the beginning of the attack.

In another female patient, admitted about the same time, certain similar features were observed. Cardiac failure supervened at one period (though not so marked), followed shortly after by a hæmatoma auris. This patient's physical condition has greatly improved under treatment. Her excitement has disappeared, and she has become an active worker, but her mental condition shows great impairment, and recovery is hardly to be looked for.

The occurrence of hæmatoma auris in both of these cases is interesting, for, whatever may be the actual cause of this affection, there can be no doubt that these causes have their origin in disturbances of the circulation, and that such disturbances give rise secondarily to the various degenerations to which the condition has been ascribed. In the two cases above mentioned there was, perhaps, reason to believe that the vessel walls were not in a perfectly sound state, though neither of the patients were at the age at which degenerations are usually to be expected.

Hæmorrhages which occur in the insane in other regions of the body have also been ascribed to degeneration* among other causes, but undoubtedly cases do occur in which degeneration does not exist. A case which I saw lately, in which an attack of acute excitement was accompanied by ecchymoses, is of interest.

(4). The patient was a woman aged 37, who looked considerably younger. She had had three previous attacks of acute mania, and her longest residence in the asylum had been less than four months. There was a strong hereditary tendency to mental disease. She was a stout, well-built, muscular country woman, of ruddy complexion and unusually delicate skin, a type in which ecchymoses most frequently occur. The cardiac action was rapid, and a faint murmur accompanied the first sound in the mitral area. On admission three days after the attack began, she was in a state of great excitement, running about, dancing, shouting, and gesticulating. She was quite incoherent, and paid little attention to what was said to her. A few small bruises were present about the elbows and knees, but these had all disappeared in the course of a few days. During the week after admission, though at times it seemed as if her excitement were about to moderate, on the whole it gradually increased. Occasional draughts of chloral and bromide of potassium secured her some sleep, and she remained quieter for the rest of the night when awake. For a large part of each day she was out of doors under special care. She spent most of the time running up and down, tossing her arms and hair about. When tired of this she lay on the ground with her limbs spread out, calling out in a state of religious frenzy that she was being crucified and stoned. One evening a week after admission, her excitement during the day having been at its height, she was found to be covered with ecchymoses. These must all have appeared about the same time, and must have been very recent.

They were most numerous on the inner aspect of the thighs, a few were visible below the knee and also on the outer part of the thighs. They were well marked on the front and inner aspect of the left arm, the chest, and back of the shoulders, with a few on the right arm. They were roughly symmetrical in distribution, of a dusky red colour, not raised, and did not fade on pressure. The largest, those found on the lower limbs, were from $1\frac{1}{2}$ to 2 inches in length and one inch broad, and were oval in shape, the smallest were circular and about half an inch in diameter. During the next few days they underwent the usual changes and gradually disappeared. In this case such causes as

* See *Journal of Mental Science*, Vol. xli., p. 678.

arterial degeneration and diapedesis may be set aside. No recognisable change in the blood was found on examination. I think there can be no doubt that the cause here was a hyperæmic condition of the skin, due partly to vaso-motor paresis or vasodilator action, and partly to the frequent and violent muscular action. The extreme congestion of the cutis was shown by other two circumstances which occurred. Shortly before the spots were discovered the patient in her excitement had bitten her thumb. The bleeding was so profuse that the attendants announced that she had bitten off a portion, but upon examination only a comparatively slight injury was found. Just at the time when the ecchymoses were first seen, her excitement was so great that it was considered advisable to give her a hypodermic injection, and though this was done with the usual precautions, it was found that a certain amount of bleeding took place. The ecchymoses, which occurred on parts considerably protected, were evidently not due to injury. This patient made a good recovery. Though she continued in a maniacal condition for some time, she at no subsequent period was so excited, and when gradual improvement had taken place was discharged after a residence of $3\frac{1}{2}$ months.

Since then such marked disturbances are produced in the general circulation by or in connection with mental conditions, it is to be expected that an examination of the pulse should afford an indication of certain of the changes which occur, whether these are the effect of the mental disease upon the heart and general physical condition, or whether they are alterations in blood pressure produced by nervous influences acting upon the vessels. Considerable attention has been paid to the subject by different observers, and various characteristic states of the pulse have been shown to accompany various forms of mental disease.* In many cases doubtless the particular variety of pulse depends to a great extent on the patient's general condition, or, as in the case of acute mania, upon the physical exertion which the patient undergoes, though it seems certain that definite forms of mental disease have their typical pulse.

The effect of the mental condition upon the circulation of particular areas of the body is shown in an interesting way in a patient whom I have had the opportunity of observing.

(5.) This woman has been an asylum patient for some years. For the first part of her residence she had long periods of comparative

* *Dictionary of Psychological Medicine*, pp. 1051, 1052, and pp. 1189, 1190.

sanity during which, though timid, shy, and reserved, she used to occupy herself actively, was neat and tidy in person, and sensible in conversation. For eight or nine months these intervals have been of much briefer duration, and have occurred less frequently. During her states of aberration she is entirely changed, does no work of any sort, tears her clothing, covers herself with dirt, is sometimes noisy and incoherent, at other times standing in a corner, looking as if on the point of an outbreak of excitement. Whenever the mental relapses occur, her hands show characteristic signs of Raynaud's disease. At first they may sometimes be blanched and cold to the touch—signs of local anæmia due to contracted arterioles—when the radial artery is found to be small. But venous congestion soon ensues, sometimes in patches, and the hands become livid and swollen, slight blebs having even been observed. The condition is seen even on the warmest days, and is unaffected by exercise.

During the remission of the mental symptoms the hands are found to resume their normal appearance. Under treatment these appearances have become less distinct.

Turning from local to more general states of the circulation, among the various alterations of blood pressure associated with mental conditions the one to which I would more particularly refer is the increase of vascular tension associated with the onset of a stuporose condition of the patient.

(6.) In the case of one chronic patient, a woman aged 58, occasional stuporose attacks lasting for a few weeks are always accompanied by a high tension, more than once apparently checked by the administration of mercurials.

In a young man who has had several acute attacks, and whose condition has become one of mild chronic mania, a stuporose attack recently supervened, and his pulse tension was found to be remarkably high. His radial artery was so contracted that a superficial examination might have led one to the belief that the pulse was very feeble, had it not been that it was found to be practically incompressible, and that pressure increased the force of the beat. The administration of croton oil or calomel, which lowered the tension, has always brightened him up a little, and he has steadily, though slowly, improved, coincident with a reduction of the high vascular tension.

The general result of increased blood pressure throughout the system is a slowing of the current, and on account of the special physical conditions under which the cerebral circulation is carried on, the effect is not less likely to be marked

in the brain than elsewhere. Such a condition of stasis will throw upon the lymphatic channels a task which they may, perhaps, not be able fully to carry out, and that such may be the connecting link between the high vascular tension and the mental phenomena of stuporose states, is further borne out by the general cerebral œdema which has been shown to exist in the brains of those dying in a state of stupor.*

(7.) In the case of a certain general paralytic, the connection of stupor with high pulse tension and with a physical condition which threatened to put a speedy end to his life was very marked, as also was the great improvement, mental and physical, which followed a reduction of tension.

It is impossible here to do justice to the interesting features which his case presented, but a very brief account may serve to show some of them. He had shown symptoms of insanity for fully two years and a half previous to the onset of the symptoms under review, and his condition was still the familiar exalted, troublesome stage of general paralysis. He was full of ambitious schemes, had lost all self-respect, and was indecent, erotic, and disreputable in his habits. He was frequently noisy at nights, pugnacious, and at times very difficult to manage. The tongue was tremulous, the speech to some extent affected, and the reflexes exaggerated.

He then passed into a stuporose condition, wore a fixed expression of face as if he dreaded the onset of some great evil, would stand in one position for hours, and was speechless, obstinate, and resistive. Shortly before the onset of this phase he had shown similar signs for some days, but an attack of influenza with high temperature had restored him to his noisy, excited, and frequently violent condition. His general health became much impaired, he was wretchedly thin, and remained in bed. Severe convulsions then occurred, with rise of temperature to 101°F. The convulsions were at first confined to and affected the whole of the left side, and when they became general were always more marked on that side.

The contractions continued without intermission for four hours, and during that time he had several exacerbations with occasional loss of consciousness.

His pulse gave evidence of marked tension, and croton oil was administered. A few hours afterwards he answered questions addressed to him, though he had not done so for weeks. Bromide and iodide of potassium were administered, and means were taken to reduce tension. He improved to a considerable extent mentally, and was able after some time to be out of bed for several hours daily. About two months after the first occasion he again had a return of the convulsive seizures. Every three or

* Etoc Demazy on "Stupidité."

four seconds spasmodic contraction of the muscles was observed, causing jerking of the leg and arm, and of the head to the left side. These continued for five days, ceasing only during a few hours, and in addition he had several attacks of severe general convulsions. Motor power was much impaired, to the extent for some time of absolute paralysis.

His pulse was of high tension, and the second cardiac sound was accentuated in the aortic area. He was treated with iodide of potassium and iodide of iron, and his condition gradually, but steadily, improved. His weight increased considerably, and he was able to leave his bed nearly five months after the convulsions began. For nine months he has been a saner man than he had been for years. He has given up his boastful schemes and delusions as to his great strength and possessions. He has been able to converse rationally, reads a great deal, takes an intelligent interest in what he reads, and remembers well the incidents of his life. He has also been able to occupy himself usefully, and assisted materially with the ordinary ward work. The impairment in speech and the pupillary signs are distinctly noticeable, and he slightly drags his left leg in walking. Means have been taken to reduce the arterial tension by the administration of calomel when required, and one or two convulsive attacks which he has had have been cut short and prevented from assuming serious proportions.

Dr. Evvan Lewis states that general widespread convulsions "usher in the gravest reductions, often leaving the subject a complete mental wreck," so that the case described must be regarded as a remarkable exception to the general rule. Given the formation of a false membrane under the dura mater, such convulsive and paralytic symptoms as this patient exhibited may be readily explained by such hæmorrhages as are known to occur in this connection, and to which a predisposition would be established by the high blood pressure.

Such, then, are some of the conditions which illustrate the connection between the circulatory system and abnormal mental processes. While in certain cases disorder of the circulatory system is a cause of insanity, much more often mental disease produces circulatory disorder, but as the diseased brain depends to a great extent for its restoration to health upon a ready response to its demands upon the vascular system, so it becomes a matter of vital importance that the disturbances set up in the latter may not have passed beyond the bounds of control. The importance of a thorough under-

standing of the connection between the two cannot be over-estimated, for, however we treat our patients, by diet or drugs, baths or massage, rest or exercise, we must to a considerable extent seek to influence the brain cells through the circulatory system.

Discussion on Dr. Edgerley's Paper.

Dr. ALEXANDER ROBERTSON—I think that the way in which the subject has been studied by Dr. Edgerley shows the true scientific spirit. I could have wished that Dr. Edgerley had shown us sphygmograms, for it is rather difficult to decide upon pulse tension and to differentiate between it and atheroma of the vessels. There is necessity for being extremely careful to appreciate what is pulse tension and what is thickening or atheroma, especially when atheroma is also present, to decide if only atheroma or high tension in addition. In some cases of stuporose insanity it is perhaps the opposite condition that exists, a languid state of the circulation in the brain. I remember showing a case of catalepsy* some years ago, in which the circulation was extremely torpid, and it seemed important to establish greater activity of the circulation by the application of hot and cold water to the head. The result was that the patient recovered. I think that recovery was due to stimulating the circulation. I observed that Dr. Edgerley largely used calomel and iodide of potassium. These are both efficacious, but I felt surprised that he did not mention nitrite of amyl or nitroglycerine in this connection. The root of the matter, however, is not defect in circulation at the outset, but a condition of the brain cells and of the nervous system, and it is often disappointing when one is able to alter the state of the circulation, to find how little effect is produced on the nervous system.

Dr. TURNBULL concurred with Dr. Robertson in appreciating the great value of the paper, and the suggestive points which were brought forward in it in regard to clinical observation and treatment.

Dr. EDGERLEY—In reply to Dr. Robertson, I may say that I did obtain some sphygmograms, but with insane patients it is difficult to get them, and when they are got the resistance which has taken place often renders them comparatively worthless; and, after all, sphygmograms are chiefly useful for demonstrating to others the features of the pulse which have already been made out by the finger.

Dangerous Lunatics Charged with Crime: Note on Operation of 15th Section of 25 and 26 Vict., cap. 54 (Lunacy Statutes, Scotland).† By JOHN CARSWELL, L.R.C.P.E., L.F.P.S.G., Certifying Medical Officer, Barony Parish, Glasgow.

The case of W. C., a boarded-out lunatic, who recently made a murderous attack upon the wife and child of his guardian, has brought under public notice and discussion several matters connected with lunacy administration in Scotland. It would, obviously, be improper to discuss questions here which are still under the responsible consideration

* *Journal of Mental Science*, Vol. xxxiii., pp. 163 and 259.

† The Scottish Lunacy Act, 25 and 26 Vic., cap. 54, section 15, provides that "When any lunatic shall have been apprehended, charged with assault or other offence inferring danger to the lieges, or when any lunatic shall be found in a state threatening danger to the lieges, or in a state offensive to public decency, it shall be lawful for the Sheriff of the County in which such lunatic may have been

of the General Board of Lunacy. Therefore I do not intend to refer to such questions, and may venture to express the hope that the subsequent discussion will be confined to the one point raised, viz., the mode of procedure adopted by the criminal authorities.

The question of the criminal responsibility of persons supposed to be insane is intimately connected with the methods of legal procedure. In other words the proof of an alleged criminal's insanity, and the provision for his care thereafter, if found to be insane, may depend quite as much upon the legal procedure adopted by the Crown as upon the actual facts and requirements of his case. That being so there is, I venture to believe, justification for bringing under review at the present juncture (while the Association is considering the question of criminal responsibility)—this case, which was dealt with under the 15th Section of 25 and 26 Vic., cap. 54.

I do not think it necessary to detail the previous history of the patient further than to say that he was first admitted to the parochial asylum in 1886, was resident there for more than five years, and has been a boarded-out patient since 1891. He suffers from dementia, secondary to melancholia, with occasional attacks of excitement. He was not of the criminal class, and had never previously committed a criminal act. On 6th January, 1896, at Ladybank, he seriously assaulted his guardian's wife and killed her child, disappeared, and was apprehended at Burntisland on the following day. After the case had been fully investigated by the Procurator Fiscal the Crown authorities decided to deal with the prisoner under the 15th Section of 25 and 26 Vic., cap. 24, and consequently he was handed over to the Inspector of Poor to be committed by him to an asylum, a guarantee for his safe custody having been given to the satisfaction of the Sheriff.

apprehended or found, upon application by the Procurator Fiscal or the Inspector of Poor, or other person, accompanied by a certificate from a medical person, bearing that the lunatic is in a state threatening such danger, or in a state offensive or threatening to be offensive to public decency, forthwith to commit such lunatic to some place of safe custody." After providing for due notice to be given, the section goes on to state that "if the Inspector of the Parish does not within 24 hours undertake, to the satisfaction of the Sheriff, to make due arrangements for the safe custody of such lunatic, the Sheriff shall accordingly proceed to take evidence of the condition of such lunatic, and upon being satisfied . . . he shall commit the lunatic to any asylum . . . and such lunatic shall be detained in such asylum until cured, or until caution shall be found for his safe custody, in which last case it shall be lawful for the Sheriff, upon application to that effect, and on being satisfied as to such caution . . . to authorise the delivery of the lunatic to the person so finding security," etc.

During the last four years sixteen persons have been dealt with under this 15th Section at the instance of the Procurator Fiscal of Glasgow. Each of those persons was found in a state threatening danger to the lieges, or was charged with a crime of violence or inferring violence. Eleven were cognosced and committed to asylums as dangerous lunatics, and the remaining five were provided for to the satisfaction of the Sheriff by the Inspector of Poor. I do not happen to have at hand the actual number of persons belonging to Glasgow charged with serious crimes who have been indicted before the High Court during the same period, and in whose cases the plea of insanity either in bar of trial or in acquittal was sustained, but it cannot be more than eight, that is to say half the number of those dealt with under the 15th Section. Moreover, it is not to be understood that these figures represent all the persons apprehended by the police and dealt with as lunatics, because a very considerable number of persons are apprehended on petty charges, and when found to be lunatics are reported to the Inspector of Poor and dealt with by him, without the intervention of the Procurator Fiscal. I have quoted these figures to show that a considerable number of persons who have committed, or have threatened to commit, serious crimes are dealt with under the 15th Section, and that they number relatively to the number of insane persons indicted on charges of serious crime before the High Court at least two to one.

The procedure to be adopted in each case is entirely at the discretion of the Crown officials, the Crown counsel in serious charges and the Procurator Fiscal in less serious charges. It is a large discretion, implying great responsibility. The public interests concerned, especially as regards the investigation by due process of law of the facts of the alleged crime, and the prevention of similar crimes, are no doubt the first care of the public prosecutor, but he has also in the exercise of this discretion to consider in the case of a lunatic what will best promote the care and treatment of the patient and his future prospects, in view of his possible recovery and liberation.

Without attempting to distinguish between the criminal lunatic department of the general prison and an ordinary asylum as regards their suitability respectively as hospitals for the cure and treatment of patients suffering from recoverable forms of insanity, I may hazard the opinion that, if choice were given, neither the friends nor the medical

advisers of the patients would hesitate to choose an ordinary asylum in preference to the lunatic department. And even in the case of a patient suffering from an incurable form of insanity the choice would still be made in the same way. Such considerations do not, of course, occupy the first place in the reasons that weigh with the public prosecutor in deciding upon the legal procedure to be adopted in these cases. His business is to protect the public from similar occurrences, but when that end can be secured without indictment it is surely right to give the patient the benefit of the less objectionable procedure.

In the case of a lunatic charged with a crime, regarding whose mental unsoundness and irresponsibility no doubt exists, nothing is to be gained as regards the public investigation of the facts of the case by indicting the prisoner and bringing him before the High Court, because the evidence taken by a judge of the High Court when insanity is pleaded in bar of trial is practically the same as that taken by a sheriff in a cognition under the 15th section.

Under the 15th section the prisoner gets whatever benefit there may be in having his case more expeditiously and less formally brought to an issue, and his friends and relatives are spared the greater publicity and cost of High Court procedure, and as a result of being so dealt with his confinement is as a patient in an ordinary asylum instead of a criminal in the lunatic department of the general prison. When the insane acts of a person who has in his insanity committed a crime fall to be considered by the public prosecutor because they are also criminal acts, the element of crime in those acts is liable to assume an importance which, from other points of view, especially the medical, it ought not to have; and thus it may happen, and, I believe, has happened, that insane persons who, having had the misfortune to be badly cared for or imperfectly nursed, and so have committed acts of violence, have been treated as lunatic criminals instead of as lunatic patients.* Moreover, inasmuch as certain offences are considered more serious from a legal point of view than others, it may occur that a patient who in his vagaries commits a number of violent acts

* In illustration of this the case of Mrs. L. may be quoted, who, in the restless and violent excitement of an attack of puerperal insanity, murdered her child, manifestly without criminal intent or even homicidal impulse. She was placed in Perth criminal lunatic department, and detained there for several years. One can hardly doubt that the proper place for her was an ordinary asylum, and the proper legal procedure under the 15th section.—J. C.

commits one that from the legal point of view is of serious character ; that man will probably find himself charged with that one act as a criminal offence, and will be dealt with as though that act was the one proclivity or impulse of his insane mind. I have within the last few days seen a case in point. A man, charged with a theft, on being apprehended and taken to the police office, was placed, unattended, for a short time in a side room. While there he removed the grate from the fireplace, placed a live coal against a door in the room, and he made an attempt to get up the chimney. The woodwork of the room took fire, but it was easily extinguished. He was then removed to a cell, one side of which has cage-like iron bars to permit the turnkey to keep watch upon cases placed there. While there he pranced about, pulled asunder some of the planks of the plank bed, climbed the iron bars, and knocked his head through the plaster of the roof, and otherwise conducted himself after the manner of a person suffering from acute mania. From the catalogue of his insane and violent acts, the one act of fire-raising was selected and made a criminal charge against him by the police, and he was thus considered to be a criminal, and possibly also a lunatic, of a particularly dangerous type ! He was dealt with under the 15th section, but, probably, he might have been quite as suitably dealt with in the ordinary way by the Inspector of Poor.

Homicide, attempted homicide, and persistently manifested vicious and violent acts are all insane acts, which should bring the accused person's whole case under the careful review of the public prosecutor ; but if the grounds upon which I have endeavoured to justify a somewhat free use of the 15th section have reason in their favour, it will not follow that procedure by indictment and confinement in the lunatic department of the general prison will be necessary in every case of even serious crime.

I am aware that objections may be raised to placing insane persons who have committed criminal acts in ordinary asylums, from the point of view that it increases the risk of accidents in these asylums, and also that to the extent to which such persons are detained as fiscal's cases, in other words as quasi prisoners, the character of the institution is changed from a hospital to that of a modified prison. The answer to the first objection is that the Legislature intended to give even dangerous lunatics the benefit of ordinary asylum care and treatment, else the 15th section would not

have been framed; and the answer to the second objection is, that it is at least better to confine a lunatic who has committed a crime as a quasi prisoner in an ordinary asylum than to confine him as a criminal lunatic in a prison.

Discussion on Dr. Carswell's Paper.

Dr. MACDOWALL (Chairman)—There is a hardship in reference to many English cases sent to Broadmoor as criminal lunatics. They are often persons who have been neglected, and have thus committed a crime through the fault of others. Take a case of puerperal mania where a woman destroys her child. She is allowed to do so by the carelessness of her friends, and I think that it is exceedingly hard that she should be sent to a criminal asylum, and that it is a disgraceful thing that the negligence of the friends escapes unpunished.

Dr. URQUHART—I think that the principle that underlies this question is, does the person belong to the criminal class? Is he of the criminal type, or is he of such distinctively dangerous habits that he requires segregation in a special institution? Every now and then we find these very virulent cases in ordinary asylums, and the consequence is that the ward in which such a person is placed is deteriorated to suit his special needs. Surely this is detrimental to the majority, and should therefore not be permitted. We know that it was enacted that Royal Asylums should not be bound to take criminal lunatics. They were specially exempted and with good reason. I rather suspect that the puerperal mania case cited by Dr. Carswell is an old familiar friend. We recognise the hardship and the impropriety of such an incident; no one here will defend it, much less argue for it; but we must be careful not to go to the other extreme. I am sure that the 15th section, with the amendments made upon it, is an admirable provision for the purpose. I only deprecate the use of it in such manner as to permit the most dangerous members of the criminal classes to evade the Lunacy Department of the General Prison, and thereby degrade and deteriorate the ordinary asylum of the county. No one at this time of day will press that all criminal lunatics should be forced into the Perth Prison. I have been told by some who know that they prefer Broadmoor to the ordinary English County Asylum.

The CHAIRMAN—Yes, I have heard that. They spend a very large amount on criminal lunatics at Broadmoor.

Dr. URQUHART—And they pay them for their work, which is even more significant.

Dr. G. M. ROBERTSON—I had a patient yesterday admitted from Broadmoor, and he said that it was not a bad thing to be a criminal lunatic at Broadmoor.

Dr. URQUHART—That is a plea for improving Perth, and not for disapproving of this particular method of dealing with criminals. I think we should exercise very careful vigilance in this matter to make sure that this side of the question is not overlooked.

Dr. ALEXANDER ROBERTSON—The law permits of milder criminal cases being committed to an ordinary asylum, and it is only those of the worst type, where a person is killed, who are sent to Perth. There is no doubt some hardship, but I see a distinct objection to admitting some such persons to ordinary asylums. There is an objection to a person who has taken away life being amongst the ordinary patients. Both patients and patient's friends feel this. The unpleasant and detrimental association should not be forced on our patients, and, as Dr. Urquhart has suggested, it is a question of making Perth more like an ordinary asylum, and so keeping such persons apart from the ordinary communities of the insane. I think there ought to be power of dealing with extremely violent cases, and removing them from ordinary asylums when they are proved to be extraordinarily dangerous.

Dr. TURNBULL—I think that everyone must feel that the 15th Section affords

very good procedure for many cases. It provides very suitably for them, and it gives a large option, which is needed to deal with the different circumstances of different cases. The point that Dr. Robertson raises is a very old and very important one. Dr. Tuke long ago argued that there ought to be a provision by which these dangerous lunatics should be capable of being removed from the ordinary asylum and placed under State care. I think there is one point that has not been quite brought out, and which it is desirable to keep in mind, namely, that if the patient gets better a very serious responsibility is placed upon the Superintendent about discharging him. If that woman whose case has been referred to had gone out and resumed married life, and again run the risk of an attack of insanity following the puerperal condition, it would be a very serious matter. I have just now a patient who committed a murder who has got better, and when he insists upon getting away I have to say to him, "Well, I cannot certify that you are insane just now, and if you insist on it I must liberate you," but when I speak to the Procurator Fiscal he says, "Is there no means by which you can put that man where he won't run the risk of breaking down again, because he cannot bear much strain?" On the whole I think this 15th Section is good, and that the large amount of option allowed by it is good, but in addition we should ask for a provision to get the dangerous lunatics transferred to places where they would be under State control instead of under the individual Superintendent of the ordinary Asylum.

Dr. YELLOWLEES—I agree with what you say. I think that each case demands caution, and is not to be determined by legal technicalities, not by the special crime, but by the condition of the patient. There is a curious way of avoiding the 15th Section which has not been mentioned. It has become the custom for a Fiscal to hand the case over to the Inspector of Poor, and to bind the Inspector not to discharge that patient from the asylum without his sanction. That is an evasion of the law and quite unjustifiable. There is no excuse for it. The Fiscal must hand the patient over to the Inspector, when he becomes an ordinary pauper case, or he must keep it as a "Fiscal" case. That middle way should not be countenanced at all. We are entitled to get the help of the Lunacy Commissioners when a case is admittedly of an unduly dangerous character, and there ought to be authority to remove such a person from our wards. There is a difficulty in discharging these Fiscal cases. It is very valuable to have the power of saying "You are sent here by the Fiscal, and you cannot get away till you are certified sane," but there is often great difficulty in discharging a person to whom nobody will give a certificate that he can be dismissed without danger, which means that the man must be perfectly recovered. Yet there are many cases which ought to be discharged if you can only stretch your conscience sufficiently to take the responsibility. I have again and again said that a man can be discharged "without any serious danger," or "without any apparent risk," but that will not be accepted. You must use the *ipsissima verba* of the Act. I appreciate the paper as discussing one of the practical questions that we should have our attention called to.

Dr. WATSON—I do not know whether the case of this patient who killed the child will come up for further consideration.

Dr. CARSWELL—No, it is finished.

Dr. MACPHERSON—With regard to what Dr. Yellowlees has said, may I ask Dr. Carswell whether W. C. is a "Fiscal" case or not? Is he a "Fiscal case" or an ordinary pauper lunatic?

Dr. CARSWELL—It is a Fiscal case.

Dr. YELLOWLEES—Is there an undertaking given by the Inspector that he won't be discharged?

Dr. CARSWELL—Yes, certainly.

Dr. YELLOWLEES—Then that is a thing not recognised by the Act, and the Superintendent of the Asylum should not recognise such a condition.

Dr. URQUHART—The section deals with a person who is dangerous or

offensive to public decency, and the fact has to be advertised in the newspapers if he is to be tried before the Sheriff. It may be modified in this way, that the trial may never come off on the Inspector agreeing to take the responsibility to the satisfaction of the Sheriff.

Dr. CARSWELL—Which is one and the same thing as the Procurator Fiscal.

Dr. YELLOWLEES—I know that the Commissioners do not think that. Such a condition has been attempted to be imposed upon me again and again, but I have always ignored it.

Dr. CARSWELL—I have gone into that point with the Fiscal, and he says that it is practically one and the same thing. Here the term "Sheriff" is used. Now the Inspector of Poor never comes in contact with the Sheriff. He comes in contact with the Procurator Fiscal, and he gives the Procurator Fiscal such a guarantee and assurance as if he gave it to the Sheriff. If necessary the Sheriff could interfere and ask for the Inspector, but that course is not followed. It is usually done through the Procurator Fiscal, the application having been made by him.

Dr. YELLOWLEES—If the patient recovers the Medical Superintendent has the same power to discharge him as if he were an ordinary pauper lunatic, as if the Fiscal had nothing to do with him. If the Fiscal wants to keep such a hold upon the patient he must commit him as prescribed by the law. On that I am quite clear. The terms of commitment must be different from the ordinary pauper form. There must be something to show me that that person is in a special category. If he comes here as an ordinary pauper lunatic, I have nothing to do with any understanding the Fiscal may have with the Inspector, and I have no communication to that effect. That section is not quoted or alluded to in the paper which sends the patient to the asylum.

Dr. MACPHERSON—When I have no official intimation I hold that I can discharge the patient when I so decide.

Dr. G. M. ROBERTSON—These cases are received by me from the Inspector of Poor, and I never get special notice.

Dr. URQUHART—I had a case lately dealt with under this section. He was a clergyman, and it was manifestly detrimental to him and to his family to advertise that he was a lunatic; and, therefore, when the Procurator Fiscal apprehended him the Inspector of Poor intervened with the necessary caution.

Dr. YELLOWLEES—But that is not a "Fiscal case."

Dr. URQUHART—Then why did the Inspector of Poor intervene? It seems to me that the whole purport of the section is to permit of action less stringent than is unavoidable on a public trial.

Dr. YELLOWLEES—Unless a man's friends intervene the Inspector of Poor must.

Dr. URQUHART—This paper was signed by the Inspector and the daughters jointly.

Dr. YELLOWLEES—That made all the difference.

Dr. G. M. ROBERTSON—I think it was for the payment of the board, that they would be responsible for any expense. He was committed under the 15th section.

Dr. MACPHERSON—No.

Dr. CARSWELL—I agree that it is proper to remove such very dangerous patients who may be inmates of ordinary asylums, but I don't think that comes within the scope of my note. I was dealing with patients before their being sent to an asylum, when they are under a charge of crime. I could have given cases that have occurred in my own experience within the last two or three years that might quite well have been dealt with under the 15th section, but were dealt with by the Crown and sent to Perth. One of them was an old woman, who, in a condition of restless melancholia, murdered her grandchild and endeavoured to poison herself. She was sent to Perth, but might have been dealt with in an ordinary asylum. As to Dr. Watson's question as to inquiry

by due process of law into all the facts of the case, I would just point out that there would have been no further inquiry than actually took place in this man's case, supposing he had been indicted and brought before the High Court, because insanity would have been pleaded in bar of trial, and he would have been forthwith committed to Perth, the facts relating to his state of mind only being brought before the Court.

Dr. URQUHART—What is the difference from a pecuniary point of view?

Dr. CARSWELL—The difference is simply that the Parish keeps the patient instead of the Crown.

Dr. URQUHART—Precisely. Is not that a feature which requires watching?

On Mental Fatigue and Recovery. By W. H. R. RIVERS,
M.D., M.R.C.P.*

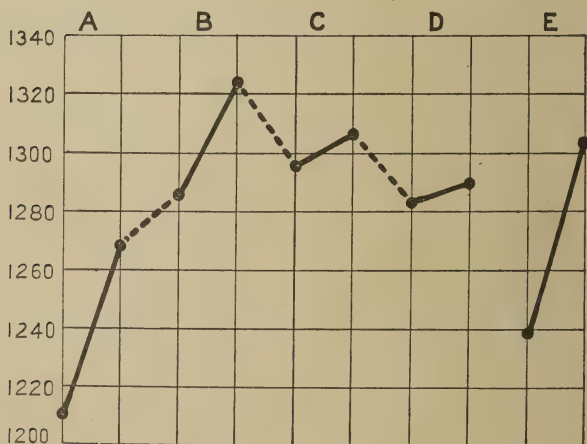
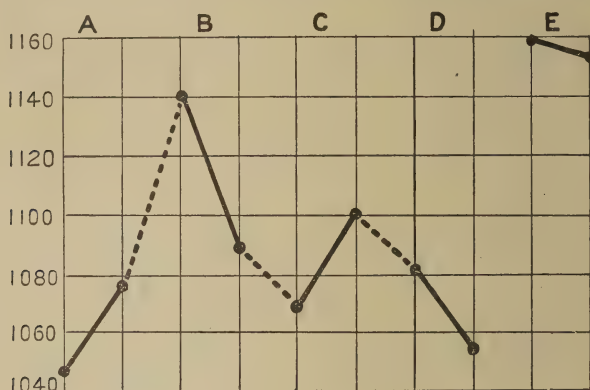
I propose, in this paper, to give a brief account of an investigation carried out in Professor Kraepelin's laboratory at Heidelberg, and undertaken with the view of gaining some first-hand knowledge of the methods I brought before the notice of the Association last July.

The problem investigated was comparatively simple; it was to ascertain the duration of the pause necessary for recovery from the effects of the fatigue induced by half an hour's mental work. The work done was addition. In this method rows of figures are printed in books, and opposite each pair of figures is written as quickly as possible the result of their addition; when the result is in two figures, only the second is written. At the end of each five minutes a clock sounds, and a mark is made so that at the end of a period of work, the number of additions done in each five minutes can be determined.

Two series of experiments were carried out, each lasting six days. In each, the period of work was half an hour. On the first, third and fifth days (long days) of each series, four periods of work were done, separated from each other by periods of rest; in the first series this period of rest was of half an hour's duration; in the second series the pause lasted one hour. On the second, fourth, and last days (short days) of each series only one half hour's work was done. The two series resembled each other in every respect except that in the first the period of rest after each half hour's work was also half an hour, while in the second it was one hour. The general results are shown in the accompanying charts, when each round mark indicates the number of

* Read at the Cambridge Meeting of the Medico-Psychological Association, 20th February, 1896. A detailed account of the investigation will appear in Kraepelin's *Psychologische Arbeiten*.

additions performed in each quarter hour. Consequently the course of the continuous lines joining the marks indicates increase or decrease in the amount of work done. The dotted lines correspond to the pauses. The letters A, B, C, D indicate the four periods of the long days, while E



indicates the work of the short days. In each case the figures give the mean of those of three days.

Before comparing the charts I may mention that all conditions were kept as equal as possible in the two series. To avoid the influence of hunger, a certain quantity of milk was taken at the end of each period of work. No alcohol was taken during the whole investigation; tea and coffee

only after the work of the day was over. The rest taken during the pauses was as complete as possible.

The normal course of a curve of work is a rise at first, due chiefly to practice and partly to the factor termed by Kraepelin "*Anregung*." This is followed sooner or later by a fall due to fatigue. On comparing the charts of the two series, it will be seen that this fall in the third and fourth periods is much greater in the first series than in the second. Secondly, if the factor of fatigue has been eliminated as much as possible from a curve of work, the curve of work of the following day should begin at a lower level owing to loss of the effects of practice during twenty-four hours, and in the second series this is seen to be the case; the work of the short days falls below in amount the end performance of the preceding long days. In the first series on the other hand, the condition is very different; the work of the short days is much above the level of the end performances of the previous days, and it may be inferred that but for the great influence of fatigue in the latter periods of the long days, the end of the curve D would have been above the level of E. A third point of difference is seen on comparing the amount of work done in the two halves of each period. In the second series in each case more work was done in the second than in the first quarter hour of each period; the line in each case rises; in the first series, on the other hand, the line shows a marked descent in the second and fourth periods, and the rise in the third period was due to a disturbing factor noted at the time which led to a great diminution in the amount of work done in the first half on one day. On two out of the three days of which it gives the mean result, the course of the line was descending.

These three differences all point in the same direction; and they show the much greater influence of fatigue in the first series and lead to the conclusion that half an hour's complete rest is wholly insufficient to neutralise the fatigue induced by an equal period of mental work. Even with a rest of one hour, the effects of fatigue were not completely eliminated.

The charts show the quantity of work done in the two series, and I also investigated the quality of the work. The number of mistakes made was extremely small; in the first series .085 per cent., in the second series .104 per cent. The number of corrections was larger, *i.e.*, cases in which mistakes made had been immediately corrected; the

numbers were $\cdot 92$ per cent., and $\cdot 98$ per cent., for the two series. The number of mistakes was too small to allow any conclusions to be drawn, but it may be noted that the second series showed a slightly greater percentage of both mistakes and corrections, and this may be connected with the much greater rapidity with which the process of addition was carried on in the second series. As regards quantity of work this investigation gives a very definite result. This result is however derived from observations on one individual only, and does not justify generalisation on the ratio of the periods of mental fatigue and recovery. I bring it before the Association chiefly as a concrete example of one of Professor Kraepelin's methods.

After some inquiries in regard to the interpretation of the diagrams, Dr. MERCIER said—We must agree that the base of all science is measurement, and in that regard the observations of Dr. Rivers are of the very highest importance, though I should be afraid they are open to considerable fallacies which would vitiate their value to a very considerable extent. The work is measured, as I understand it, by the addition of pairs of figures. Two figures are added, then another two, and so on, and the numbers of pairs of figures which have been added are taken as representative of the work done during a certain period of time. The method seems, on the face of it, to be a fair one, but as a matter of fact and experience it is a very much easier thing to add together certain pairs of figures than certain other pairs. For my own part 7 and 3 make a couple which in common addition I always treat as one figure, they are so easily added together, whereas 8 and 3 I have to pause over. It is a much longer process to add 8 and 3 than 7 and 3. In the same way 5 and 6 always take me considerably longer than would 8 and 4, and so on, and I suppose we all have idiosyncrasies of this kind which would render it harder for us to add together certain pairs of figures than other pairs, so the actual amount of work done in a given time is not strictly represented by the number of couples of figures added together. Supposing a difficult couple were to occur very frequently in one series, the work done in adding that series together would be considerably greater than if that difficult couple occurred more seldom and easier couples more frequently. So although it is a test, probably as good as can be taken, yet it is by no means a certain and absolute test of the amount of work done in a given time. I am not prepared to suggest a better, and I welcome very heartily any method which can be devised for applying the science of numbers to our mental processes, but I am afraid it is open to that fallacy, and it may be to other fallacies which I won't take up the time of the meeting by mentioning, which may possibly vitiate the results. It is particularly desirable that work of this kind should be undertaken, but at the same time I fear the results will not be commensurate with the amount of labour involved in obtaining them.

Dr. WIGLESWORTH—I quite agree with Dr. Mercier as regards measurements, and that these results are very much to be welcomed, but I do not think they have so far given us any information we did not possess before. It is extremely interesting to have knowledge confirmed in this highly scientific manner; at the same time we were already acquainted with the fact that when we commence mental work the commencement is never so good as the secondary period, *i.e.*, in the second half hour our mental activities are very much keener than they were when we first sat down. I don't know whether Dr. Rivers has any explanation to offer of that. I think it is largely due to the vascular supply, the brain attracting to itself a larger amount of blood as the work is proceeded with.

Dr. BOWER—I take it that measurements of the mental abilities of individuals are not confined to adding up figures. There are other methods, as, for instance, by

committing to memory certain words; and individuals would vary in the ability displayed in their various methods. For example, in committing words to memory, I am certain I should be a long way behind a great many others, and possibly in adding figures I should be considerably ahead. I think there was one point with regard to which Dr. Rivers' measurements did give some new information, viz., that half an hour of rest is not enough to counteract the result of half an hour's work.

Dr. RAYNER—The suggestion which has already been made that the work would have been done better if the vascular supply had been thoroughly established, is one which strikes one forcibly, and the question is whether that may not be the reason why, with a short period of rest, there is no falling off of work, whereas in the longer period there is; the vascular supply having fallen to its low level in the longer period of rest, and not in the shorter period. One would like to know whether Dr. Rivers has made any observation with regard to the external temperature of the head during his observations. One knows in active mental work, especially such work as that of adding up figures, the temperature of the brain externally rises rapidly, and of course it falls more or less rapidly. I should think it would be of interest to observe whether the rate of falling bears any relation to the rate of loss of power of work in the five or fifteen minutes' period.

The PRESIDENT—I think, gentlemen, that it is much easier for us, knowing so little about this question, to see the great difficulties in regard to arriving at any conclusion of a practical sort. Perhaps it is right we should do so, because when entering upon any great field of investigation which requires most complete accuracy to substantiate the results upon which to build the ultimate fabric, we have to deal with factors that we are not completely and thoroughly acquainted with. No doubt each one of us knows the kind of work which he affects, and any one of us in this room might easily begin a comparison in his own mind by asking himself with what amount of spontaneous energy he is able to sit down to a rubber of whist, or with what amount of spontaneous energy he is able to sit down to write out his case book. I think that in a test of this kind, if a sufficient number of individuals could be got to compare their individual experiences, that ultimately some conclusions might be arrived at, first of all at the length of the period of what is called "anregung" here, and, on the other hand, the duration of the period of depression, where the work has an element of boredom in it. Again, one individual could take to himself and compare in his own mind the results with regard to this question of practice and of fatigue and recovery from fatigue from a succession of winning or losing rubbers at whist. It is a very simple comparison, involving an element of excitement, and each one of us might be able to compare what period it took us to recover from the fatigue involved, not only where the rubbers were successful, but where the rubbers were unsuccessful. It is very difficult to get at the kinds of work that are interesting to individuals, and being able to institute that comparison is the only possible method to ensure accuracy of results. I think that the question of what I might call the spontaneous energy of individuals is of great moment, but that is a long way ahead of those more simple introductory methods such as Dr. Rivers has submitted to us to-day. With regard to this, at any rate it is quite evident that results of a practical sort can be arrived at. Whether they may be beneficially applicable is another matter, but no doubt Dr. Rivers can tell us his own variation as regards the capacities he has on one day for doing certain work, and the amount of fatigue he has had to recover from before he is able to come up to his normal standard. There is no doubt that whatever difficulties there may be in the wide and extensive application of work of this sort its immediate interest is very great, and that with a sufficient number of investigators carrying out work on the same lines in the end the science may be so applied as to be valuable and beneficial to us in our dealings with the results of mental fatigue or with the results of diseases arising from mental fatigue. I think we must be extremely grateful to Dr. Rivers for having brought forward his experiments and results on a most important line of inquiry.

Dr. RIVERS, in reply, said—I am familiar with Dr. Mercier's observation that

some additions are easier than others, but Prof. Kraepelin's addition books are so arranged that this cannot appreciably affect the result. In my own case, the difficult numbers are those which make 13 or 15, but I found that this difference disappeared to a great extent in the course of the investigation. Dr. Wigglesworth made a point with which I must disagree. He said there was nothing in this we did not know before. As a matter of fact, there was something in it which Prof. Kraepelin, with his large experience of mental work, did not know before, and that was that half hour periods of rest are not sufficient, far from sufficient, to get rid of the effects of half hour periods of work. I brought my experiences forward this evening chiefly as an example of work done by these methods. That work, standing alone, is, I acknowledge, of very little use, but taken in conjunction with all the other work which is being done by Professor Kraepelin and by his school it may be of greater value. As regards a physiological explanation of "anregung," I may mention that Kraepelin finds it to be a factor also in muscular work. As regards the question of external temperature, so far as I know, no observations have been made in connection with this special kind of work. I do not know whether Mosso has made such observations. At present it seems to me that what is really the greatest difficulty with regard to these methods is the question of *interest*. These methods of mental work are not interesting, and the interest one can get up in them cannot be very great. Whether one is entitled to draw conclusions from these uninteresting methods of work to work which is interesting is a question of the greatest importance. I hope it may be possible to carry out some kind of experimental investigation of this question of interest.

*Remarks on the Nursing Staff in Asylums.** By P. W. MACDONALD, M.D., Dorset County Asylum.

The subject matter of this paper can hardly fail to be of special interest at the present time, when so much attention is being given to, and so much done for, the nursing staff of every asylum.

It therefore needs no apology from me to ask for your consideration and friendly discussion of this question, for we must all recognise that whatever success may attend our efforts, we are largely indebted to the nursing staff.

That there is a wide divergence of opinion as to how we can best secure and retain the services of an efficient staff I am well aware, and perhaps it was this fact more than any other that induced me to bring the subject before you to-day.

At a meeting of the Association held at Oxford in February, 1894, an able paper was contributed by Dr. Menzies† on "The Future Supply and Status of the Nursing Staff." From time to time opinions are ventilated in the pages of medical journals, and paraphrased in the daily

* Read at the meeting of the S.W. Division of the Medico-Psychological Association, 14th April, 1896.

† *Journal of Mental Science* for July, 1894.

press. Then there are many able and valuable suggestions within the covers of the Annual Reports of the asylums of this country. And yet again there is the special teaching and training of asylum nurses and attendants, which some would have us believe is destined to be a panacea for all existing and future evils. Wages have advanced, leave of absence has been extended, uniform is universal, palatial halls and separate blocks have been erected, and all with one and the same object: a true desire to remedy defects and improve efficiency.

Notwithstanding, there does not appear to be any material change for the better in the length of service. Comparing the Asylum Reports of last year with those of ten or fifteen years ago, and from the same pens, we have the same hackneyed phrases, expressing regret "that the changes among the staff have been numerous," or "that the higher wages and increased leave of absence," etc., have failed to reduce the too frequent changes.

Now, I am not one of those who believe that changes, even among the senior members of a staff, are always to be regretted. For I have known an old hand do incalculable mischief; yet at the same time the good nurse or attendant is invaluable, and while the work does not suffer because of advanced years they cannot serve too long.

There is a consensus of opinion that the class of the ordinary asylum nurse or attendant is improving, advancing, and this is one of the pivots on which we should concentrate our energies. For though there are exceptions I think it will be admitted that the better grade of nurse or attendant is more likely to become efficient, and with proper treatment more likely to take an intelligent interest in the work.

The question of lady nurses in asylums is one on which I have an open mind, but at the present time there does not appear to be any strong desire among Superintendents to try them. I know that there are lady nurses in some of our public asylums, and I have had the very best accounts of their work, while others have frankly admitted that their experience of lady nurses had not been encouraging. If by lady nurse you mean the woman who thinks more of her personal appearance than the comfort of the patients, who fondly believes that her duties can be discharged while reclining in an easy chair, who thinks she is there to be gazed at and not to work, who hates everything and abuses everybody, then I unhesitatingly say save us from such

nurses. But if you mean the hard-working woman who wishes to earn an honest livelihood, who is neither afraid of, nor shrinks from the unpleasant, and who can accommodate herself to the monotony and irksomeness of asylum life, then by all means let such women take their place on the staff of every asylum.

In considering the question of lady nurses in asylums it is very necessary to remember the real and apparent difference between the spirit animating the hospital probationer as compared to the asylum probationer. When a young woman of 18 or 20 desires to enter an institution to be trained as a general nurse she almost invariably does so because of her inherent fondness or supposed calling for the work; but I ask you how often do such motives attach to a similar individual applying as a probationer at an institution for the treatment of mental disease? What is common in the one case is exceptional in the other, and though a matter for regret not altogether one for surprise. No doubt the desire to possess the wherewithal lurks in the background, and one is therefore tempted to say—why not choose the more lucrative post? The asylum nurse is better paid than the hospital nurse, and there are the additional advantages of more frequent promotion and the prospect of a pension; but all these advantages do not equalise the difference between the work of applying a poultice, dressing a wound, or taking a temperature, and the ceaseless strain of having charge of a suicidal, dangerous, excited, or troublesome patient. Again, whereas the hospital nurse has few opportunities of acquiring special knowledge in the treatment of mental cases, the asylum nurse can become an efficient sick, as well as mental nurse.

I cannot say that I have found lady nurses of much use in the ordinary wards of a public asylum, but there is a wide field of usefulness for such nurses in the private patient department, and a short experience has fully confirmed my earlier notions that their presence and services are much appreciated by the lady patients. Though capable of taking their part in the routine duties, they are mainly lady companions, and as such I consider them necessary.

There is not the same difficulty with attendants, many of whom are trained disciplined men, though experience has proved that the raw untrained country youth makes the best attendant.

Whatever may be individual opinion regarding the social

status of nurses, I think we are all agreed that the chief of the nursing staff should be a thoroughly trained, educated person. When these ideas and thoughts were run together, now more than twelve months ago, I was strongly in favour of having a lady at the head of the nursing staff, but partly from personal, though mainly from collateral experience, I have to own to a modification in my views. Yet, while admitting that facts and experience have caused me regrets, I am still of opinion that, if you can but meet with the proper person, a lady is to be preferred.

It may be asked—why not a lady? Well, I will give you a few of the reasons. In the first place the monotony of asylum life is not conducive to the maintenance of a high standard of contentment in woman's mind; and, however strong may be the desire to encourage harmonious relations between superior and subordinate officers, I question the ultimate good of social equality, and with whom can the lady chief nurse associate other than the medical officers?

But, apart from the social question, there is a much more important element, viz., the actual duties of the office. Now, on this point, I am fortunate in being able to pick the brains of several valued friends in the specialty. One regrets to have to admit that his lady chief nurses have invariably become little else than lady's companions, and he has been compelled to appoint working head nurses. Another says the cause of failure is, "that there is not a sufficient amount of true nursing duties, *i.e.*, surgical nursing, to engage their attention," and that the drudgery and irksomeness of asylum life chill the best intentions.

So far my observations have been of a general character, and it would serve no useful purpose were I to enumerate the various known causes of the too frequent changes among the staff. Facts are of more practical value than theories, and I am anxious to have your criticism on what has been done at the home of my present labours to grapple with this vexed question.

I have already said that higher wages, etc., have failed to materially raise the standard of contentment or increase the length of service. Nay, I have it from experienced Superintendents, that the spirit of discontent and restlessness is on the increase. What, then, may we infer from such facts and expressions of opinion? Do we not recognise that money, holidays, and shorter hours are not everything to these workers, and that there is a danger of neglect of

what is of the greatest importance—minor domestic comforts. I do not believe that the nurses and attendants in the asylums of this country wish for an “eight hours day,” nor do I believe that there is any general dissatisfaction with the present rate of wages and leave of absence; but I consider the present uncertainty as regards any fixed pension a distinct grievance, as well as a main cause of many leaving the service. Among domestic comforts their bedrooms are in the front rank. These rooms should be pictures of furnished comfort and neatness. The subject of food, especially dinner, is a fruitful source of complaints, and why it should be so I am at a loss to understand. The dinner should be arranged weekly, and every endeavour should be made to introduce variety. The adoption of this system is a powerful check on irregularities and grumbling. I feel constrained to add that the red tape system of fixed allowances is largely concerned in the recurring complaints on this subject.

The privilege of having their annual holiday in two or three parts should not be denied to those who may wish it divided; half days and single day's leave of absence are greatly appreciated; married attendants should be allowed to go home every evening after eight; the day staff should not be required to do duty after the patients' bed-hour; and last, but not least, there should be several sitting, or recreation-rooms, instead of, as is the case in most asylums, but one. This last point is of the greatest importance; for there are grounds for believing that the large common sitting-room is productive of quarrels and discontent. It is not just to ask 40, 30, or even 20 nurses or attendants to share the same room; and it cannot be right to allow them to remain about the wards nor to retire to their bedrooms (except when off duty), no—nor even as was suggested to me by a high authority, to sit in the ward sculleries. I have been greatly impressed by the objections of better class nurses to the general recreation-room, and time tends to strengthen my opinion above stated.

If the medical officers devote many of their spare hours to the training of the staff, I cannot believe that they are called upon to teach either nurse or attendant, who, just as the course of training is over, and the first uniform is growing shabby, resigns, and for no better reason than the love of a change. With a view to checking this, a simple and effectual practice has been adopted at Dorchester. When the usual

period of probation has elapsed, the probationer is informed that before uniform can be granted two conditions must be agreed to. First, the lectures must be attended, and, second, he or she must agree to stay in the service of the asylum for at least one year. I might add that sickness or domestic affliction would excuse the non-fulfilment of the second condition. Though voluntary, the system works admirably and the results are decidedly encouraging. It has checked resignations after six or nine months, and just when nurses and attendants are becoming useful. An experience of three years enables me, with some degree of confidence, to recommend this system to the consideration of brother Superintendents.

On looking through the records of many years, I was impressed by the number of resignations after three to five years' service. I think we generally find that if a nurse or an attendant stays one year, they are likely to stay two or three; and then it frequently happens that for no better reason than the innate love of change they leave, and the same is true at a later period. Remembering the value attached to all kinds of decorative rewards, I conceived the idea of a special recognition—something that they could leave as an heirloom to their children, something that they could show and feel proud of possessing, something descriptive of their work. I suggested to the Committee that they should award medals to all members of the staff for good conduct and long service. The suggestion was favourably received, and they decided to grant three grades of medals: a bronze medal for 5 years' service, a silver for 12, and a gold for 21 years. I believe I am correct in stating that the Dorchester Asylum was the first to adopt such a system.

I may be told that a medal is given in connection with the certificate of proficiency in nursing; but, in the first place the Dorchester medals existed before any other single asylum medal, in the second place they are awarded for good work, good conduct and long service, and in the third place the medals are the absolute property of those to whom they have been awarded. Whereas the so-called Association medal is given for answering a few questions, which is no guarantee of a thorough nurse or attendant. I am in favour of teaching and training the staff, I have already said that such is an integral part of our system, but I wish to sound a note of warning against the prevalent and rather absurd practice of recognising these parchments as proofs of

efficiency. In the course of conversation I have been peculiarly gratified with ready and voluntary expressions of thanks. That these medals will serve as a great and extra inducement to long service, and a fresh and special stimulus to good work, I have not the shadow of a doubt. Though the authorities of the Dorchester Asylum can claim priority in this new departure, the field was not long their own. For, towards the end of last year, the Committee of the Derby County Asylum adopted a similar system of medals with the addition of gold stripes, and Dr. Lindsay writes to me saying that the medals are greatly appreciated.

I do not wish to inflict on you any extended reference to anonymous communications, but I have to ask for your indulgence while I briefly refer to one or two of recent date. Quite recently *The Hospital* opened its columns to the anonymous effusions of a number of discontented asylum nurses; but as I have no experience of the staff being served with uncooked meat, under-boiled potatoes, and raw vegetables, no—nor of studied insults from the medical officers, I would ask any nurse or attendant to name the asylum where they are thus treated, and I will not hesitate to assist in exposing such an iniquitous system of management.

In the *Medical Magazine* for October, 1894, there appeared an anonymous article on the nursing staff in asylums, and were it not that the author signs himself “An Asylum Medical Officer,” I would not allude to his curious ramblings. He may be a very wise, learned, and experienced asylum officer, but when the human mind lends itself to the influence of inexperience you naturally expect what you here find, valueless painted notions with artistic friezes of vile abuse. Now with regard to these anonymous mental vapourings and midnight soliloquies, I cannot conceive any course more calculated to retard progress and injure prospects than the publication of ill-natured, ill-advised, and offensive remarks.

In bringing these humble observations to a conclusion, I wish to say that there has been no attempt to cover the whole field, my object rather being to submit for your consideration certain definite facts and methods, which, rightly or wrongly, I believe to be of far-reaching importance as regards the nursing staff; and I further wish to say, that while aiding and assisting the true spirit of scientific research in the study and treatment of mental diseases, we should, at the same time, foster and build up a nursing backbone of loyalty, contentment, and tried experience.

Discussion on Dr. MacDonald's Paper.

The CHAIRMAN, in opening the discussion, said they were all very grateful to Dr. MacDonald for putting so tersely before them his observations on this most important subject. Although they might not be able to find such assurances in every case, yet the success which appeared to have attended the Dorsetshire authorities in meeting the requirements of the nursing staff, and in meting out rewards for services rendered, by means of medals, was, he thought, an indication that they were on the right tack. Dr. MacDonald had given them much food for discussion, and he hoped those present would speak their minds, because they did not wish that Dr. MacDonald's experience should be unreasonably weighted with the authority that might seem to attach to it, for so long as nursing staffs were composed of individuals whose human natures were what they were, they must necessarily find a large variation in their results. His experience at Broadmoor was that when a room was specially provided the nurses preferred not to go to it, but had a desire rather to get outside the walls of an evening when opportunities arose. They were certainly not particularly anxious to sit down and talk to each other when they had so very many opportunities in the day time with results of a varying character.

Dr. STEWART was glad to hear the remarks of Dr. MacDonald with reference to lady nurses. He presumed by the term "ladies" he meant "gentlewomen," because every shop girl was a lady now. Gentlewomen in an asylum were not likely to be successful, perhaps for other reasons than those to which Dr. MacDonald had referred. The character of the conversation made the society of the insane particularly repulsive, and it would be very hard for a gentlewoman to get accustomed to the constant filthy expressions which the most refined patients, even in private asylums, sometimes use.

Dr. COBBOLD said he was specially interested in Dr. MacDonald's reference to the failure of the single large recreation-room. He had experienced himself that such was the case in at least three County Asylums with which he had been connected. The nurses in the majority of cases preferred going to their own bedrooms. The introduction of the system of presenting medals struck him as being excellent, and a valuable addition was the bestowal of stripes for long service. He did not know whether there was also an addition to the salary at Dorchester for good conduct, but it had been the rule for many years in the service of the Metropolitan Asylums Board. It was also so at Colney Hatch, though not paid as part of the wages, but merely on the special recommendation of the Medical Superintendent.

Dr. BENHAM said his experience had been somewhat peculiar. When he became Superintendent, now some six years ago, the first duty he had to perform was to discharge every male attendant on the premises. He was pleased to say that he had succeeded at last in getting a staff who were giving satisfaction, and who he believed would promote the discipline on the male side of the house. With regard to the women, situated as he was in the neighbourhood of a large city, he had no doubt experienced much more difficulty in obtaining nurses than was found in country districts, where there was not so much of the modern spirit of unrest. He thought many women brought up in the country were more inclined to settle and accept the irksome duties of asylum nurses than those accustomed to the excitement of town life. Two or three years ago it became a very pressing question with him to increase the efficiency of the female staff. The first step was to get the nurses to go in for the St. John Ambulance Association "first aid." They sent up a large number of candidates from both sides of the house for that examination, and those who passed obtained the badge of the Association, which they proudly wore on their left arms. Then those that had passed, and had seen two years' service in the asylum, were trained for the certificate of the Medico-Psychological Association. He certainly thought that as a result of this the nurses took a more intelligent interest in their work. He was glad to say that there were no nurses in his asylum who could hope to obtain promotion who had not obtained both the badge and certificate, and there were now many of them waiting for promotion who had gained both, so that there

would be no trouble in that direction. With regard to the certificate of the Medico-Psychological Association, the recipients received a gratuity of £2 at the end of each completed year's service from the time the examination was passed, provided good conduct had been maintained in the interval. This continued yearly as each completed year ran its course. Those who passed also received a medal, which on leaving the asylum became their own property if their conduct had been good. The medal was made of silver, and was a handsome ornamental one. Both nurses and attendants at his asylum wore it with pride. With regard to the subject of food a very difficult question arose, and Dr. MacDonald seemed to have been exceptionally fortunate in having had but few complaints under this head. One endeavoured to remedy complaints as much as possible, and was glad to say that when this was done the persons concerned were ready to express their satisfaction and appreciation. As to the big recreation-room, he might say at once that many of the nurses at his asylum did not go to it at all. The attendants received a fair amount of leave—they did not go out every night in the week, neither did he find, especially among women, that the desire was general to do so—but they had the privilege in the summer months of going out into some parts of the asylum grounds. For some years past this privilege had been granted under sufficient safeguards, and there had been no reason on his part to regret it. He thanked Dr. MacDonald, and fully concurred with the opinions expressed in his able paper.

Dr. BOWER said he joined in the expression of gratitude to Dr. MacDonald. One matter he had had some experience in was with regard to ladies in asylums. While he was at Edinburgh they introduced lady companions among the patients. That was in a private asylum, and the remarks of Dr. Stewart, which he was rather sorry to hear, bore on private as well as on public asylums. With regard to the objectionable language, he thought there was another side to be considered. The knowledge of ladies being present in the sitting-rooms with lady patients was a very great check on the use of objectionable language. He found during the time he was at Edinburgh that ladies had a refining influence on the patients and attendants. They found that they were able to trust the lady nurses, better than the ordinary attendants, to appreciate the necessity for constant supervision in certain suicidal and dangerous cases. He helped to introduce the system there, and certainly had no reason to regret it. He did not think that the lady nurses would do in substitution for the ordinary attendant. He quite agreed with Dr. MacDonald in that, but as an addition he was quite sure they worked a great improvement in the treatment of patients. He was especially interested in hearing of the various inducements to keep attendants. He had usually found great difficulty in keeping on attendants after they had served about a couple of years.

The CHAIRMAN remarked incidentally that the Treasury had been good enough to sanction an allowance of a month's pay to female attendants at marriage, provided they had been on the staff for six years. It was rather putting a premium upon marriage, but he thought it was a very suitable recognition of long service. This happened just before he left Broadmoor, and he did not know whether anything had been done in the matter with regard to County Asylums.

Dr. COBBOLD said there were always gratuities under the Metropolitan Asylums Board.

Dr. WADE remarked that, according to the Government auditor, no gratuity could be allowed after service ceased.

Dr. MACDONALD said that, as usually happened at such meetings, the very people one expected to open their minds refrained from doing so. (Laughter.) He thought he might conclude that everyone who had spoken had agreed with him in condemning the large recreation-room. His remedy was that two or three should be provided, where the attendants could sit and meet together in small groups as they liked. He disapproved of medals which had been earned being given up on leaving the asylum. The remarks which had fallen from Dr. Bower with regard to lady nurses he was very glad to hear, because they practically confirmed his own experience.

The Special Reports and Certificates required by Section 38 of the Lunacy Act of 1890, and Section 7 of the Act of 1891. By R. S. STEWART, M.D., D.P.H.Camb., Deputy Medical Superintendent, Glamorgan County Asylum, Bridgend.

“We very much doubt whether this table will ever show much diminution on these numbers, for as time goes on the work of special certification will become more difficult and intricate.” So writes in the January number of the *Journal of Mental Science* the reviewer of the last Report of the Commissioners in Lunacy for England and Wales regarding the Table (Appendix B) which gives the number of readmissions on fresh reception orders rendered necessary by the previous order having expired under the Lunacy Act, 1890, sec. 38.

With the two opinions here expressed we are unable to agree. With regard to the first, what do the Commissioners Reports since the Act came into operation show? The numbers of such readmissions for the five years 1891-94 are as follows :—

Year.	Total Number.	Per cent. of Total Admissions.
1891	344	1·86
1892	182	·95
1893	119	·59
1894	99	·51

Readmissions under this heading are therefore steadily diminishing, and there is no reason why this should not continue.

In the second place, the work of special certification, *with a properly devised system*, need not, as time goes on, become more difficult and intricate. That some such system is required is apparent enough. Of the sixty-eight English County and Borough Asylums, three only—Berkshire, Colney Hatch, and Claybury—have so far been successful in not allowing the reception order of one single patient to expire by overlooking the special report and certificate required by section 38, or, at all events, in avoiding a re-admission due to such an oversight.

The amount of trouble, worry, and expense connected in these cases with the formal discharge, the obtaining of fresh certificates and reception orders, and the subsequent formal admission is by no means inconsiderable, and on these and

REPORT DUE ON JULY 30.					DATE OF LAST REPORT.												
No.	Name.	Date of Reception Order.	Date of Admission.	Result.	1891	1892	1893	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903
4185	J. H.	Aug. 20, 1890	Aug. 30, 1890	—	Aug. 9	Aug. 9	—	July 30	—	—	—	—	—	—	—	—	—
4189	S. P.	„ 30, 1890	Sept. 1, 1890	—	„ 9	„ 9	—	„ 30	—	—	—	—	—	—	—	—	—
5062	S. T.	„ 30, 1893	Aug. 31, 1893	Died	—	—	—	„ 30	—	—	—	—	—	—	—	—	—
5733	W. R. E.	„ 30, 1893	Nov. 5, 1895	—	—	—	—	—	Aug. 1	—	—	—	—	—	—	—	—

other grounds it is desirable that such readmissions should be at the very least reduced to the minimum.

To be a success it is necessary that any system that is adopted should be simple in the extreme, and this was the object kept in view in devising that which is in use in this asylum. For the purposes of this section the only really important point is the date of the reception order, for it is this alone which determines the date upon which the special report and certificate fall due, and the earliest possible date is the one which proves the simplest in working. In a book called the *Register of Renewal Reports*, there is a separate folio for each day of the year, and each admission as it occurs is entered under its appropriate date. The accompanying is a sample of such a folio.

The right hand page is devoted to the date of the last report, and on each occasion of entering this, the years upon which no report falls due are lined out, so that in the current year one can at a glance see which reports are then due. The scheduled cases whose reception orders are dated on or prior to 1st February, 1890, are kept separate, and entered as falling due for report on 1st April.

The system of collecting the cases into weekly groups was tried, but was found to become increasingly cumbrous and complicated as time went on, and it was given up in favour of the

daily method. Discharges and deaths are recorded at the same time as the entries are made in the statutory register, and a line drawn through the columns on the right hand page to close the case.

With some such system as this, and with ordinary care, there is no reasonable excuse for the overlooking of a report when it falls due; and it has this further distinct advantage that it retains its simplicity all down the years.

Atypical and Unusual Brain-Forms, especially in Relation to Mental Status: A Study on Brain-Surface Morphology.
By W. JULIUS MICKLE, M.D., F.R.C.P. (London), President-Elect, Medico-Psychological Association.

CHAPTER I.

General Considerations—Normal Standards of External Brain Architecture—New Details of Unusual Forms of Convolutions and Furrows—Many Deviations from Type accepted from Several Observers—Chief Deviations from Usual Form in Brains examined by the Writer, and the lines on which they occur; their significance and appraisal from a general point of view.

In an Address* in the Section of Psychology at the Annual Meeting of the British Medical Association, London, 1895, I touched upon some of the results of an analysis of many necropsies I had made, with regard to abnormal forms and arrangements of brain convolutions, and mentioned the dissatisfaction one had felt with some of the accepted standards of convolutional form. With regard to unsatisfactory standards of normal brain-form, it was stated in the Address that "we may take it for granted, and need not tarry to prove, that a different normal standard of brain-form obtains in different stages of individual life, in different races of mankind, and, as a logical inference, must obtain also in different ages of the world and epochs of time; for what practically concerns us at the moment is the normal set of standards for modern British brains. The standards of the normal, hitherto chiefly in use, and with which I began, were unsatisfactory, defective, incomplete, insufficient in range, and even misleading. For their unsatisfactoriness

* "Presidential Address," delivered July 31, 1895. Published, *British Medical Journal*, Sept. 28, 1895.

there are several reasons. One is that some of them have been diagrammatic or schematic, thus unduly accentuating some features and minimising or omitting others. Another is that the brains from which certain figures and descriptions are drawn have been taken from dissecting-room subjects, or from patients—most of them ‘incapables’ of various kinds, dying in rate-supported or State-supported institutions—of whose life-history little or nothing is known in many instances; who often are failures in life—waifs and strays—broken fragments of the wreckage of civilisation, the indication of degeneracy and breakdown. And such failures, waifs and wreckage are they very often—most often, indeed—because of their mental defect or perverted aberrant type of mind, which not infrequently has as its accompaniment, sometimes pathological brain change; but sometimes also, or solely, has an abnormal brain development and aberrant gyral conformation. Indeed, knew we their ancestral and life-history fully, we would search such subjects for some of the most interesting forms of convolutional deviation from type. And still more would this be the case, if, especially in the past and in some countries, dissecting-room subjects have been largely recruited from the criminals dying in prisons, and the mentally decayed and defective dying in asylums. Therefore it is not surprising to find that sometimes the brains taken from the sources previously referred to, and published as typical, are what I do not hesitate to declare and describe as being brains of deranged or of defective development, and utterly misleading if taken as normal.”

It was also claimed that their full significance must be assigned to other coexisting conditions, and these were set forth in the Address.* Yet, giving due place to the considerations mentioned there, I concluded that there still remains over a body of evidence as to the existence of particular conditions and details of brain architecture which are marks or indications of low type of brain and mental organisation; of defective and deviating types of brain development, correspondent to defective aberrant types of mental action and of outward conduct, and that, within a certain definite range, there is an agreement between brain conformation and clinical psychiatry. These conclusions were drawn from my examination of a very large number of brains.

* *Loc cit.*, p. 757.

In the Address were also briefly considered some more or less new points of inferiority or deviation of type—of defective or aberrant development—of gyres and fissures, which I have observed, which were new at the very least in the sense that they were not known to me as being noted by others. On search it was found that certain of these points had received brief mention, or had place in some detailed descriptions or figures of individual brains, but, like other unheeded details in these, had not been the subject of special attention. Only a very brief summary of these special points learned from my observations, and already published, will be given here and first, and then the chief deviations in type of convolucional architecture in the brains I have examined will be systematically considered, those which have been accepted from other observers being (in that part of this article) taken conjointly with those which I have brought forward.

NEW DETAILS OBSERVED BY PRESENT WRITER.

The points learned from my observations, and stated here in very brief summary, are as follows:—

The more general departures from usual or typical form in any of the directions mentioned on a later page—superiority—irregularity—inferiority.

(a.) I have found anomalies of the gyral architecture more frequent in the right than in the left cerebral hemisphere, even after making allowance for the fact that, at least according to my observations, the normal standards of right and of left cerebral hemispheres differ somewhat between themselves in man.

(b.) Another of the points of more general kind is expressed in irregularity of gyres, and much irregular division and subdivision of them by the unusual aberrant course, depth, length, forking, or reduplication of ordinary sulci, or the existence of unusual ones. It is essentially dissimilar, not only on the one hand from an inferior type marked by few and simple gyri and sulci, but also, on the other, from a normal type of highly-endowed brain, rich in folds and anfractuositities.

(c.) An islet of cerebral cortex is occasionally formed by unusual aberrant forking of a principal sulcus, or a fissure, the spurs fully reuniting after enclosing an islet of cortex; as, for example, in the case of the central fissure, or the parallel sulcus, or interparietal sulcus.

The more local departures from usual form.

These will be described more fully later on, together with other atypical conformations of the same parts.

(d.) The tendency to an irregular circle of furrows en-girdling parts of the temporal parietal and limbic lobes or gyres from the temporal tip back again to the same, and consisting chiefly of the parallel, interparietal, parieto-occipital, "stem," and collateral furrows.

(e.) The next condition is the formation of a parietal operculum overhanging part of the occipital lobe; the reverse of the simian occipital operculum, and for this reason I termed it a *reversed occipital operculum*. It is a parietal operculum, directed backwards; or opercular state of the parietal, and more of the inferior than superior parietal lobule.

(f.) The formation of what I have termed a *præcuneolus*, or an *anterior cuneolus*. It consists in the superficial insulation or peninsulation, on the mesial surface, of a portion of the quadrate lobule—usually its upper posterior area—triangular or squarish in shape, or its posterior strip; either by a forking or reduplication of internal parieto-occipital fissure, or, occasionally, by a sulcus cutting through from the upper to the mesial hemispherical surface.

This condition has important relations to the annectant gyres, and the island or peninsula, as a rule, is apparently formed by a depressed, inbending, mesially-directed sub-structure, or continuation fold, of the first external parieto-occipital annectant gyre.

(g.) The formation of what I termed a *cuneolus* or *posterior cuneolus*. It consists of an unusual form of the superior internal parieto-occipital annectant gyrus, and of the cleft bordering it posteriorly; which last now drives deeply into the cuneus, ploughing off the upper anterior triangular area of its surface. In some examples, indeed, there is what practically amounts to a forking of the internal parieto-occipital fissure.

And, again, an upper and posterior and irregularly triangular part of the cuneus may be cut off by a sulcus from above; in some cases, indeed, incising the cuneus to the calcarine fissure, or almost so.

The new applications of the terms mentioned above are made merely for brevity and convenience, and save much repetition of description.

(h.) Unusual conformation of the *præcuneus* other than

that already mentioned under “(f).” Extraordinary irregularity may characterise the quadrate’s sulci, which, as well as the subfrontal fissure anterior thereto, may take on a most bizarre arrangement.

(i.) The next condition to mention is the close proximity, in their somewhat parallel course, of the transverse occipital sulcus to the external limb of the parieto-occipital fissure, so that these are only separated from each other by a narrow ridge or very slender fold.

(j.) Next, is an unusual or an abnormal variation of the normal issue of the deep temporo-parietal annectant gyri and deep temporal sulcus from the first temporal gyre; so that the external surface-substance of the latter, or a large portion of it, turns from forming part of the lateral aspect of the temporal lobe, twists sharply, plunges into, and entirely disappears in, the Sylvian fissure; and therewith the parallel sulcus apparently becomes continuous with the deep temporal or other sulcus, and loses its way into the Sylvian gutter. In such case a variety of unusual conditions may concern the isolated representative of the true posterior continuation of the parallel sulcus, which restarts immediately behind an interrupting, raised, bridging, anastomotic, gyral fold.

(k.) The first temporal gyrus may be partly divided by fissurets running upward and backward, the first temporal sulcus being in segments so disposed, or branching in that direction.

Much more often, the second temporal gyrus is partly divided by fissurets directed downward and backward, such practically representing the second temporal sulcus, or part of it, in a sectional form.

Thus the sections of the latter gyrus and sulcus are in a direction at about a right angle to those of the former.

(l.) Extremely irregular divisions of the lower parietal tier may occur, it being much and irregularly incised by bi- and tri-furcation, or by unusual branching, or by unusual and prolonged extension of sulci, of the first temporal sulcus especially; also by irregularity and zigzag state of inter-parietal sulcus, or by a far descending, and perhaps forking, external continuation of parieto-occipital fissure; or by an unusual form of sulcus intermedius (of Jensen).

(m.) Similarly, the upper parietal tier may be affected; and one, two, three, or four oblique sulci may partly divide the superior parietal lobule into several sub-gyres. These

furrows may run obliquely backward and inward, and some, over the edge to the mesial surface of the hemisphere.

(n.) Next, are furrows from the Sylvian fissure ploughed vertically part (occasionally two-fifths) of the way up the middle of the external surface of one or both of the central gyres. In some examples, these may denote an unusual extent, and somewhat aberrant or less favourite position, or duplication, of the incisions of the frontal and parietal opercula from the Sylvian. It is less likely that they ever represent duplication of postcentral or precentral sulcus elements.

(o.) Certain states of frontal sulci, especially as concerns the third frontal gyre. These, with others relating to the same parts, will be stated in detail in a later chapter.

(p.) The frontal convolutions may be, more than usually, ploughed or subdivided by short fissurets directed forward, upward and inward. The secondary gyres thus formed have the same upward, forward and inward direction on the supero-lateral frontal surface as have their bounding and separating sulci. This gives an appearance of deviant line of direction and oblique thrust to the frontal convolutions, as if they were twisted in their forward course so as to trend forward, upward, and inward, in a diagonal direction, as if the second and third frontal gyres sought the frontal tip, and the first gyre the mesial surface.

Chief Deviations from form described by a number of observers.

Other observers have found a number of deviations occurring in brains, as, for example, in those of certain kinds of criminals, those of some persons of weak intellect, or insane. Of these deviations, there is reason to accept some as being significant, to reject others, and to accept still others in a partial manner only, only partially accepting these inasmuch as they are valid only when in conjunction with other specific conditions, disjoined from which they cease to have the same significance; in some cases, indeed, bear a very different meaning. *Like words in a sentence, their meaning varies with their context.* To this variation of meaning with the context I shall frequently recur in the following pages, for it is a very simple and useful simile to impress on the mind the fact to which it refers.

The above specified details, as well as some but little noticed hitherto, together with conditions previously stated in full by others, and accepted as departures from usual

form or from type, will presently be described conjointly, *as far as they occurred in brains examined by the writer*. But the following account is not exhaustive; a number of rare, or at least infrequent, departures from usual form, or morphological aberrations or peculiarities, will be omitted, the object being to include here only the more usual and more practically useful.

Deviations from the usual forms and arrangements of convolutions of the brain present conditions possessing very different and sometimes even contrary significance. Gyres and fissures deviate from the usual conformation in ways essentially distinct, independent in origin, boldly contrasting in interpretation. They may deviate from the ordinary average state, in the direction of superiority; or in that of aberrant irregularity or bizarrerie; or in that of inferiority by defect or by retrogression. The first shows active development and high evolutionary grade; the second shows formative activity, and perhaps over-activity, but lower in kind, ill-directed, aberrant; the third indicates defect of development, or else evolutionary reversion.

Therefore, superiority, irregularity, and inferiority of gyral and fissural states are the three great lines of departure from the usual average and normal. Of these the first does not require division, so far as our present purpose is concerned; the second may conveniently be conjoined with the third as being also essentially one kind of inferiority, and, as far as concerns our immediate purpose, may well be merged in the inferior. And, so, deviations from the usual form of gyres and fissures may be considered in their several kinds, according as they are due to one, or other, or several of the following factors, namely:—

1. Development defective, weak, slow, imperfect.
2. Development deranged, perhaps active, but giving rise to irregular and strange forms.
3. Development arrested more or less, with persistence of foetal character in place of advance to adult form.
4. Reversion towards brain-type of lower races of mankind.
5. Reversion towards types of brains of lower animals, especially apes.
6. Developmental superiority.

In what immediately follows, on the subject of deviation of brain-gyres and furrows from usual type, an endeavour will be made to estimate the meaning and significance of

These departures from rule. When they constitute deviations which merely indicate evolutionary advance and a departure from form necessitated by the higher grade, position, and functional energy of the brain concerned, recognition of their true character is as much required as in the case of the others which mark morbid aberrancy or defect; although it is these latter kinds to which attention must be restricted in one of the future articles of the present series. For it is only abnormal defects or aberrations which can take part in the constitution of a standard or criterion of abnormal surface-conformation of the brain, amounting to a stigma, or sign-group, of hereditary mental degeneracy; those, and those only, being relevant to the subject of the future article just mentioned.

CHAPTER II.

In this and the succeeding chapters will be included:—

1. AN ACCOUNT OF THE CHIEF DEVIATIONS FROM TYPE AND DEFECTS IN CONFORMATION OF GYRES AND FISSURES IN THE BRAINS FORMING THE BASIS OF THESE ARTICLES.
2. REMARKS UPON, AND ESTIMATION OF, THE SAME.

Under each heading are taken the chief deviations of form and of relation found by the writer in the external cortical architecture of a series of brains. Under each, are taken together both those which were previously stated by other observers, and also those brought forward by the writer, and briefly stated in summary above. These chief deviations, with remarks upon and appraisement of each, will be divided as follows:—

A. First, will be concisely stated a few general conditions, *i.e.*, conditions which may exist simultaneously in various and separate parts of the brain.

B. Next, the more definitely local or individualised states will be described and commented upon at some length, as they affect individual lobes, gyres, and furrows.

A.

MORE OR LESS EXTENSIVE OR GENERAL CONDITIONS.

The greater frequency of cortical architectural deviation from normal form in the *right cerebral hemisphere* than in the left, has already been mentioned.

Nor need one repeat what has been stated above, under

the heading of newer details, on the *irregularity* of gyres, and their irregular subdivision produced by unusual states of furrows.

And I have sufficiently described the formation of *islets of cortex* by division and reunion of the main trunk of a *principal* furrow. Such an islet of cortex rising in the channel of a principal furrow, and produced, as it were, by a forking and prompt reunion of the main trunk of the sulcus, is indicative of *aberrant* formative activity.

Departure from the standard of *relative size of the several lobes* of the cerebrum is distinctly observable in some cases.

Microgyria is sometimes found with defective brain-type.

Large islands of cortex may be quasi-insulated by communications of sulci, chiefly of primary ones, the shores of the irregular islands being formed by conjunction of several different sulci, of which some may be supernumerary furrows, or unusually developed secondary sulci.

Unusual fissure-forms.

Unusual fissural states may be produced by irregular course and extension of known sulci, as, for example, furrows which run downward and backward upon or near the temporal surface, or pass therefrom to the inferior cerebral surface, perhaps ploughing it up almost to the hippocampal or calcarine fissures.

Unusual furrows may also be made by an abnormal duplication of ordinary furrows.

Constituted in either way—and in the former, perhaps, not very appropriately named here—these indicate a perversion in developmental activity; in the former case showing defect of annectant gyral folds, together with luxuriance of branchings and undue extension of anfractuositities; and in the latter case, namely, that of duplication of ordinary furrows, showing perverted activity of formative action—action excessive in degree, lower in grade.

A fissure-girdle or furrow-girdle.

I have sometimes found an irregular, complete or almost complete circle of fissures and sulci engirdling a large part of the cerebral hemisphere, from temporo-spheroidal tip, back again to the same point, or nearly so. It is formed by the conjunctive communication of a number of furrows; namely, the parallel, the interparietal (or not), the superior

and mesial limbs of the parieto-occipital, the conjoint stem, the lingual (or not), the collateral fissure, and the temporal incision. This subject will be mentioned again when speaking of the collateral fissure.

This fissure-girdle shows inferiority of development, inasmuch as it indicates a *relative* defect of the annectant gyres in the course of the girdle, which normally should interrupt and separate its constituents. It also shows undue extension of sulci, and unusual length of the temporal incision (of Schwalbe).

Passing from these conditions, which have a more or less extensive range, we now come to consider the individual lobes and gyres and furrows.

Under each heading, the chief atypic states observed in the brains examined by me will be briefly reported, and some commentary and estimate concerning those states will follow. Successive chapters will be devoted to the mesial surface; the occipital lobe; temporal lobe; parietal lobe; central gyres and fissure; and frontal lobe.

CHAPTER III.*

B.

UNUSUAL OR ABERRANT MORPHOLOGICAL CONDITIONS OF INDIVIDUAL LOBES, GYRES, AND FURROWS.

MESIAL SURFACE.

(a.) *Subfrontal fissure (calloso-marginal fissure).*

This may be irregular, and may seem to fork posteriorly. It may end with an upturn further forward than usual, and even in front of the central fissure; or may end with an upturn further back than usual and well behind the post-central sulcus; this latter is perhaps more indicative of hereditary defect. The fissure may be in two chief sections, the hinder of which is considerably the lower in the anterior part of its course. It may appear more or less practically doubled. In one such case, the lower furrow of the two ended, posteriorly, above the middle of the corpus callosum, considerably short of the usual situation of the up curve. The upper furrow of the two threw out spurs, continued much further back than the other, formed a sort of abortive up curve; then shallowly joined the sub-parietal fissure,

* This chapter and the next one are not yet in complete form at the time required for press.

and, conjointly with the latter, blended with a bold furrow running vertically to the upper edge. Occasionally a variety of the double sub-frontal fissure appearance arises from an unusually long and deep intra-limbic sulcus. The sub-frontal fissure may run low down and not reach the upper hemispherical surface by its upturn, but a sulcus, one-third of an inch behind and parallel with this, does reach the upper surface. The condition may be partly due to a deep annectant attaining the surface. Or the posterior upturn of the sub-frontal may seem to fork, one spur running to each side of the upper end of the Rolandic fissure.

With one (right) sub-frontal fissure upcurve situate far back, the other (left) may be in the usual situation. Posteriorly, it may have two or three upcurves, *e.g.*, one joining with, or partly forming, the pre-oval sulcus, one opposite to the central fissure, and one behind the post-central sulcus. Or it may throw three nearly vertical branches to the upper edge of the hemisphere, the most posterior of which springs from a stellate subparietal approaching the corpus callosum.

The sub-frontal may be connected with a bold sub-parietal fissure, nearly insulating the quadrate lobule from the gyrus fornicatus, receiving the transverse parietal sulcus, and running into, or nearing, the sinus of the corpus callosum.

The posterior upturn of the sub-frontal fissure may be short, the posterior portion of the horizontal part of the fissure being oblique and not far from the upper border. In such case the upturn may send a spur into the quadrate; in such case, also, the posterior arc of the fissure may be very arcuate; contrary to what one would expect.

(*b.*) The *fornicatus* may be smaller than usual or irregular in shape; and either it or the *marginalis* surface (Fr. 1) may be more or less divided into two tiers. The fornicatus, however, has a much less relative size in primates than in lower mammals.

(*c.*) The *pre-oval sulcus* (paracentral) has been stated to be convex backwards. But sometimes there is only a slight or indistinct limiting sulcus; and when it *is* present in well-defined form I have often found it somewhat concave in posterior aspect (instead of convex), or practically neutral in that respect, or presenting a double curve like a long *f*, or the same reversed. In foetal brains it is usually set with the concavity backwards.

COMMENTARY.—Brief commentary on the above states of

mesial surface observed in brains will especially concern the sub-frontal fissure.

Sometimes one finds an appearance as of two or even three quasi-sub-frontal fissures, the one or two extra furrows seeming like abortive sub-frontal fissures. By this means more or less of the part of the mesial aspect of the anterior half of the cerebral hemisphere, situate between the gyrus fornicatus and the upper hemispherical border, is divided with greater or less completeness into two or even three tiers of gyri.

This we may take as partial duplication or triplication of the sub-frontal fissure (or "vegetative repetitions" in some?), and indicating aberrant formative activity. Or, in some cases, they might plausibly be taken otherwise, and as an abnormal persistence, in the adult, of a foetal character, which is sometimes shown by brains in the seventh and eighth months, and the dawn of which may be observed in some brains of earlier months.

But, probably, we have in the appearance as of two or more (partial) sub-frontal fissures in the adult brain, a condition the status of which varies, and is often to be appraised by the context of conditions amidst which it is found. For, as already said, a morphological brain-condition often varies in its meaning with the various other conditions with which it is associated; much as the words in a sentence may vary in significance with *their* context. In examples of the formation in question, if the other accompanying conditions are aberrant, defective, or reverting, then may this formation also be taken as of the same nature. On the contrary, if the accompanying conditions evince a normal or a high brain type, this formation may perhaps be deemed to manifest the same in its gyral and fissural wealth and luxuriance.

But when—other things, hereabouts, normal—the anterior half of the mesial surface above the fornicatus is shallowly divided into two tiers by a series of short fragmentary sulci, arranged sagittally in line one after the other, and perhaps connected by slight grooves, I take it that, so far as it goes, this indicates superiority of brain instead of the reverse.

Deviations of the sub-frontal fissure from usual form are apt to be accompanied with aberrant appearances in other parts of the mesial aspect of the brain. For example, with duplication, real or simulated, of the anterior reaches of the fissure, together with a broken and very irregular course of its posterior portion, there is a tendency, in some cases, for

the sub-parietal fissure to be very irregular, beset with spurs, and oblique or somewhat vertical; and also for the calcarine to be irregular, deviant in form and relations, and interrupted behind by a superficial bridging gyre.

Although it is not interlobar, but is an intragyral sulcus, the chief (first, or upper) super-orbital incision (of Broca) (sulcus rostralis), by its course and connections, has seemed to me as belonging to the sub-frontal fissure system. Its direction and sweeping curve, its close resemblance to the anterior arc of the sub-frontal fissure in many of the cases in which the latter is interrupted, so that the several arcs thereof are distinct; its frequent inverse relation of size and development with the anterior arc, its occasional entry into the latter, its variation with the superficial or deep position of the pre-limbic annectant gyre, its length and constancy in man, and its presence in all primates—seem, collectively, to speak of it as a part, or adjunct, of the sub-frontal fissure group.

It is often to be seen in foetal brains at various ages. When this is the case in some examples figured it is found to be labelled as an early or representative element of the calloso-marginal fissure. Or, on the other hand, it has been held and depicted as continuing into the larger metopic sulcus, or as forming an element in a sulcus of the comparatively early foetus to which the same name is applied, and which may not be accompanied by any sulci near it on the mesial aspect. But I think this is incorrect, and that in the examples last referred to there is before us an early form of an element of the sub-frontal fissure (calloso-marginal) itself (or of an arcuate precursor in the earliest examples), and that in the interpretation of appearances omission has been made to give due allowance for the rapid growth and shifting relations of neighbouring mensial portions of the frontal lobe.

The sub-frontal fissure, proper, was found:—Not interrupted, by Sernow in $71\frac{1}{2}$ per cent., by Giacomini in $67\frac{1}{2}$ per cent.; with one interruption, by Sernow in $24\frac{1}{2}$ per cent., by Giacomini in 28 per cent.; with two interruptions, by Sernow in 4 per cent., by Giacomini in $4\frac{1}{2}$ per cent.

Sernow found the fissure single in $44\frac{1}{2}$ per cent., the arcuate portion more or less doubled in $55\frac{1}{2}$ per cent. As variants of the former were one or two interruptions of the single fissure. As deviations from the complete double arch of the latter were shortness of one arch, division of

arches into sections, presence or absence of union of one or of both arches with the vertical piece.

Eberstaller observed the fissure single in 68 *per cent.*, doubled in 30 *per cent.*, scattered in two *per cent.*; and the simple single form decidedly more frequent on the right side, the double form more frequent on the left. There does not seem to be adequate basis for making the schematic type of the fissure to be of double form.

Although the fissure is long and single in some cases, the tendency is to send off superficial or deep annectant gyres mostly directed upward and backward, and flying off, as if centrifugally, from the fornicatus and corpus callosum region, and toward the hemispherical border—at all events, until the posterior arc of the fissure and the resistance of the oval lobule are reached. This form is found in a number of foetuses in the sixth, seventh, and eighth months, and its persistence in the adult, often at least, marks undue retention of a foetal character.

It is variable in time of first appearance during foetal development, and in the older foetuses may be stated to vary in form, direction, and division much as in later life.

The parts above-described have been much confused. In some figures of brains the super-orbital elements and those of the sub-frontal fissure, proper, are arbitrarily, self-inconsistently, and sometimes erroneously, named or lettered. The same remark applies to the delineation of other furrow-elements on the anterior half of the mesial aspect of the cerebrum, as, *e.g.*, those which divide that surface more or less into superimposed tiers, in some brains. It necessarily follows that this gives rise to divergent and arbitrary identifications of the gyral elements, the interpretation of *their* extent and limits being guided by those of the furrows dividing and bounding them. Therefore, undue curtailment or extension of fornicatus and, inversely, of marginal and super-orbital elements, is sometimes depicted.

The annectant gyres crossing the sub-frontal fissure play an important part. Running out of the gyrus fornicatus, they may become superficial and completely divide the fissure into several separate arcs, chiefly crossing the anterior arc; or between the anterior and middle arc; or between the middle and posterior arc, and hereabouts are sometimes two; or crossing in the course of the posterior piece, and shallowing the junction between the main horizontal stem of the fissure and its posterior vertical upturn. But in

some cases interdigitating gyrels* cover the walls of the fissure pretty well all along the posterior half of its horizontal reach. The posterior of the two incisions bounding one of these usually deep, occasionally superficial, annectant gyrels may take part in the formation of the pre-oval sulcus bounding the *oval lobule* in front, a sulcus often ill-formed and very variable in shape, position, arrangement of component parts, and constitution; nearly always present, in some degree, in man and most apes, and absent only in the lowest of the primates. It is sometimes boldly marked in the human foetus. We may, therefore, briefly consider this lobule, called *paracentral* by Betz; together with its limiting sulcus, *solco inflesso* of Lussana, *pre-oval sulcus* of Broca, *paracentral* of Schwalbe, *inflected* of Wilder.

On the upper hemispherical edge, and adjoining mesial surface, shortly in front of the line of the superior pre-central sulcus, is often a depressed little pit or fossette, usually more or less continued, below, on the mesial aspect, in furrow form. This is a frequent and important element of the pre-oval furrow. But there are others. Where a (usually deep) annectant gyre crosses from the gyrus fornicatus to the posterior part of mesial aspect of first frontal convolution, the furrow indicating the posterior limit of the upper insertion of this superficial or deep annectant gyre on the frontal lobe, serves to form part of the pre-oval sulcus. A spur from the sub-frontal fissure also frequently takes part in the formation of the pre-oval sulcus, communicating often with the other elements just mentioned. In some cases the sulcus is formed almost completely from the upper surface; in others partly thence and partly from the sub-frontal region below; in others from below.

The first of the above-mentioned elements is named "*sulcus præcentralis medialis*" by Eberstaller, who argues that what has just been mentioned as a spur from the sub-frontal does not form part of the anterior limiting sulcus, but is in front of the true *sulcus præcentralis medialis*, and separated from it by the mesial root of the first frontal gyre. Nevertheless, he admits that in 55 per cent. they *do* communicate at a deep annectant gyre, although the two pieces differ in depth. But this so-called *sulcus præcentralis medialis* is not an element of the precentral sulcus system;

* If I may coin and use *gyrel* as a diminutive of *gyre*.

it usually lies in front of the plane of the latter; it does not mark the anterior boundary of the anterior central gyre so far as the surface tells; it trenches on and cuts off a small posterior part of inner aspect of root of first frontal gyre. By Flesch and Familant it was taken to represent the carnivore sulcus cruciatus, a homology claimed by Betz for the sulcus spoken of as limiting the oval lobule in front.

Moreover, the "paracentral" lobule, often so-called, is not paracentral. The posterior central gyrus is a constituent of it, at most, to a slight extent only, notwithstanding that the gyre contributes a band of grey and white matter which forms part of the whole length of the posterior bank of the lobule, over against the reach of the upcurve of sub-frontal. And the anterior central gyrus does not fully form it, the back end or root or roots of the first frontal convolution, at least often, contributing somewhat to its formation. Thus it is not co-terminous and co-extensive with the mesial ends of the two central gyres. From a truly "paracentral" lobule it differs by processes both of exclusion and of inclusion. Oval lobule is a better name, as given to it by Pozzi and Broca.

The pre-oval furrow, often curving, usually diagonal, occasionally vertical, is often short or imperfectly developed.

When a boldly defined spur from the subfrontal is borne towards or to the hemispherical border, on the posterior flank of a superficial annectant gyre, and thus appears as preoval sulcus, the oval lobule may also be partly or entirely divided, either, as in one of the brains before me, by a curved intra-oval incision or fossette nearly joining an accessory præcentral element on the mesial aspect, namely a spur there, from a tri-radiate sulcus on upper surface; or, as in another brain, by an irregular precentral sulcus element, and by a spur from sub-frontal, like a premature abortive upturn, slant-wise forward. To term such as these "pre-oval sulcus" seems to be incorrect. Yet, in a case very similar to the former, an upward spur of the intra-oval incision has been depicted and named as pre-oval sulcus, erroneously I think.

Other things equal, the following would denote superiority:—

A well-marked pre-oval sulcus and delimited oval lobule.

A single, or but once-divided, sub-frontal fissure, well provided with deep or partly superficial annectant gyrels.

A moderate and interrupted sub-division of mesial surface

of first frontal gyre, by a linear series of furrows, sagittally thus dividing that surface into two longitudinal superimposed tiers; and with numerous vertical and oblique radiating furrows, as if seeking the upper hemispherical edge. The furrow-group dividing that surface longitudinally I would name the mesial frontal intra-gyral sulcus. According to the concise but full abstract by Stieda, from the Russian work, Sernow does not mention it, merely stating that on the gyre are many secondary furrows, mostly radiating from near the arcuate portion of the callosomarginalis. And Eberstaller says it is only seldom there is any antero-posterior division of the medial aspect of the first frontal convolution. I have found it fairly often, however, and arranged as above described. I see it is figured by Brissaud.

Other things equal, the contrary conditions would denote relative inferiority.

Another mark of superiority, *cet. par.*, is a well-developed super-orbital sulcus, with two accessory super-orbital incisions.

Conversely, small size, imperfect development, and fewness of super-orbital furrows tell for inferiority (*cet. par.*).

The upper and chief so-called super-orbital sulcus exists in all primates, the first so-called accessory one in man and anthropoids, the second in man only, and inconstantly.

Failure of the posterior upturn of the sub-frontal fissure to reach the upper hemispherical edge denotes aberrancy and defect of conformation, as in lunatic or in microcephale. Reduction of the normally sharp posterior upcurve to a slight gradual flexure of the general line of the horizontal portion of the sub-frontal, thus producing curtailment of the lower part of pre-oval lobule, brings about resemblance to the ape-form of the fissure; marks inferiority; may occur in small-head idiots, in whom also the anterior portion of the fissure may be irregularly developed or broken up, but seems to be always represented more or less.

It has been held that the posterior ascending terminal vertical piece of the fissure represents, in the human brain, the sulcus cruciatus of the carnivore brain, and that in primates this *posterior ascending end of the sub-frontal fissure*—but in osmatic animals and marine mammals the *front end of the sub-parietal fissure*—bends up as sulcus cruciatus. In relation to this view, Eberstaller offered the explanation that

this so-called posterior ascending end-piece of the sub-frontal fissure is really a morphologically independent furrow-element, which in the former case (brains of primates) joins the sub-frontal fissure, this being, in them, predominant and separate from the sub-parietal fissure; but in the latter case (brains of other animals just mentioned) joins what is in these the much stronger sub-parietal fissure, owing to relatively defective influence of frontal brain. I have mentioned above a deep annectant gyrel somewhat obstructing the bed of the fissure at the junction of its vertical upturn with its horizontal main line, and he observed two exceptional cases in women (and one in a foetus) in which this usually deep annectant was superficial, thus cutting off the vertical end-piece entirely from the rest of the sub-frontal fissure, and in one of them the vertical piece made an uninterrupted union with the sub-parietal fissure, and presented a form "completely analogous" to that of the sulcus cruciatus of carnivora.

At the beginning of this chapter are mentioned two examples of very complex and unusual connections and relations of sub-frontal upturn and sub-parietal fissure. They are essentially similar to the case last cited. In one (left) the sub-frontal fissure sent up a spur or abortive upturn in front of an almost completely superficial annectant gyre which crossed between fornicatus and back part of oval lobule, directed nearly vertically. Athwart this annectant gyre ran a slight groove recurving from the spur in front, and joining it very shallowly, behind, with the true upturn of the sub-frontal, which last at its lower end united with the sub-parietal fissure, over a moderately sunken gyrel. From about the middle of the sub-parietal a flexuous and irregular, nearly perpendicular, sulcus was given off, and attained the upper hemispherical edge. Much of the first temporal gyre sank into the Sylvian fissure, and the temporal region, generally, was very irregular and anomalous. Other parts also were atypic.

In the other (right) there were three upturns or spurs, two being false, and the backmost the true one. This last was completely cut off from the horizontal reach of the sub-frontal fissure, by an entirely superficial vertical annectant gyre, and the lower part of the upturn was directed backward as well as downward, and united with the sub-parietal fissure over a sunken gyrel. The sub-parietal also sent a spur downward and forward deeply into the forni-

catus; the spur-tip closely approaching, but not meeting, the pointed end of a similar spur from the back end of the horizontal reach of the sub-frontal fissure, and directed deeply downward and backward into the fornicatus. Both the sub-parietal and the transverse parietal were somewhat irregular; and the posterior vertical spur of the former just fell short of union with the latter. The central fissure failed to attain the upper edge by $\frac{1}{8}$ inch. Other parts of the brain were of unusual form.

A third patient had a much less unusual condition. The anterior parieto-limbic annectant was sunken to half depth or more, where the upturn of sub-frontal crossed to join the sub-parietal; the upturn also sending a deep, bold spur downwards and forwards to the brink of the sinus of the corpus callosum.

In some examples the usual superficial parieto-limbic annectant is depressed at its lower part, and the upturn unites nearly as much with the sub-parietal fissure as with the horizontal part of the sub-frontal. Or the posterior upturn of the sub-frontal may send a spur into the quadrate lobule behind a deep annectant gyre. In relation to these forms certain schematic representation of the sub-frontal as typically—and, one is left to infer, usually—uniting with the sub-parietal fissure, errs on that point, according to my observation.

QUADRATE LOBULE: OR PRÆCUNEUS.

The formation of a præcuneolus (or anterior cuneolus).

The condition as observed in brains.

Long ago I observed what at first I called, for convenience, the formation of an *anterior cuneolus*, but subsequently the formation of a *præcuneolus*. Most frequently it consists of the superficial insulation or peninsulation (as far as concerns the mesial aspect) of the upper and posterior area of the quadratic surface, of triangular or wedge-shape or squarish form, and situate between the main line of the mesial part of the parieto-occipital fissure and a spur, or sulcus, which is not of the same origin in all examples.

A. Most frequently this latter furrow is the anterior prong of a forking vertical part of the parieto-occipital fissure, and I find that Broca, in a few words, mentions that incisions may pass thence into the quadrate or cuneus.* In the simplest

* Just as this goes to press I have met with a figure from Wilder, by Mills, in which the cut-off is shown and somewhat similarly named.

and peninsulating case this spur ends just short of the upper hemispherical edge; or in the simplest insulating form the fissure only notches the upper cerebral surface at the verge of the interhemispherical chasm. But when the deviation from usual form is more considerable, this branch of the fissure may be continued far out on the upper lateral surface of the hemisphere, and with a course and relations to which we will presently recur. Yet in some cases the portion of the cortical area of the quadrate, thus superficially isolated, is not cuneiform or triangular, but is oblong or squarish, the sulcus cutting it off being rectangularly bent, as if representing a tooth (and its adjunct) of a Neptune's trident. In still other examples the insulated area consists of the posterior narrow band of quadrate's surface, bordering on the parieto-occipital fissure, and marked off from the rest of the quadratic surface by a fissure-duplication of this vertical part of the parieto-occipital, close to, and parallel with, the latter, and ascending from the "stem," or close thereby.

B. But in some other cases the quadratic island or peninsula is apparently formed otherwise. For although at first glance it appears to be produced like as in cases in which the insulating branch of the parieto-occipital fissure is boldly carried to the upper and lateral cerebral surface, yet further study of the parts seems to show us a furrow beginning near, or at, or beyond the interparietal sulcus, and running thence inwards, or backwards and inwards, into the great cleft, and then down on the quadrate to, or nearly to, the parieto-occipital fissure, or reaching the latter by a shallow confluence. This represents a deviation of the spur, from the interparietal, bordering part of the anterior meander of the first annectant. Occasionally it may represent a parietal furrow (of Jensen) situate far back, or a duplication of the same. What are abnormal are its position, relations, and effect, and it is of less immediate concern to establish its identity. Yet possibly the apparent differences between the two sets of cases are sometimes partly due to a bridging, or an incomplete one, at the origin of the peninsulating branch of parieto-occipital. And, indeed, the general accompanying conditions, and the other signs of defective or aberrant type of brain-development, are much alike in the two.

In some cases the *præcuneolus* is more or less sunken or partially hidden.

In some such cases it is obviously a depressed and mesially curving portion of the first occipital gyrus, forming the first

external annectant parieto-occipital gyrus, or is a deep annectant substructure attached thereto. This observation might be taken to favour the view of Bischoff as to the superior internal annectant gyrus of Gratiolet in apes being homologous with the first external annectant gyrus, or its representative, in man, and therefore that in man the one of these, or its representative, is absent when the other is developed; and to disfavour the opposing tenet of Ecker. But sometimes one finds on the parietal wall of the median limb of the parieto-occipital fissure, two gyral coils, in semi-circular relief, descend to the depth of the chasm, and, closely hugging one another, cross to ascend, blent in one, on the occipital wall. And of these half-rounds in relief, in the former situation, the upper is obviously related to the first external, the lower to the first internal annectant.

COMMENTARY.—In the human foetal brain may occasionally be seen the foreshadowing of the formation of a præcuneolus or anterior cuneolus. This is usually vague at first. But the full-time foetus may exhibit a distinct incomplete præcuneolus, and with this may be other signs of unusual conformation, as *e.g.*, a cuneo-limbic annectant gyrus rising to the surface, or a prong of the conjoint stem also ploughing up into the cuneus. And a tendency to, or degree of, the formation of a præcuneolus is observed in some examples of microcephaly. While in the higher apes (*e.g.*, chimpanzee) a partial similar peninsulation is sometimes or at least occasionally seen.

The condition is an example of deviation and formative activity rather than of defect and formative inertia; in the human adult is a somewhat unusual conformation which, although in some cases of developmental character, often indicates a reverting tendency and phylogenetic significance.

When a posterior marginal zone of the quadrate is cut off by a duplication of the internal limb of parieto-occipital fissure, the state is like the doubling of the parieto-occipital fissure occasionally observed in anthropoid apes.

Other deviations or anomalies of quadrate lobule than those already mentioned.

Besides the anomalies already mentioned, the quadrate may be lessened by the far-back coming of the sickle of the calloso-marginal; or, on the other hand, the unusually forward upturn of the latter may leave the quadrate large. Its upper and anterior corner may be shallowly insulated. It

(Q) may be almost completely fissured off from the fornicatus; and it is often furrowed through to the fornicatus by the parietal (of Jensen). It may be invaded by extraupcurves or branches of the sub-frontal fissure, or it may be much split by vertical or oblique fissures, or may be the area of conjunction of rami of sub-frontal and parieto-occipital, or of sub-frontal and transverse parietal sulci. Extraordinary irregularity may mark the quadrate's furrows, which—as well as the parts of the sub-frontal or other furrows anterior thereto—may take on the most bizarre arrangement.

Division asunder of the sub-frontal fissure occasionally permits union of an anterior parieto-limbic with a fronto-limbic annectant.

Conditions often associated with the above deviations of the quadrate, or with the frontier—or cuneal—states subsequently described.

Associated either with certain cuneal, or with frontier, states, yet to be delineated, or with the præcuneal conditions described above, are, often, other aberrant or defective conformations in the same or in adjoining parts of the brain.

For example, in some cases there is some degree of continuity of the “stem” with the hippocampal fissure.

In some, the cuneo-limbic annectant gyrus (Zwickelwindung), which in an undisturbed state of the parts should be sunken and concealed, is abnormally found to be more superficial and obvious than usual.

Or the vertical part of the parieto-occipital fissure may bifurcate or trifurcate boldly when nearly arrived at the upper edge of the hemisphere; or may send long spurs furrowing the cuneal surface, or præcuneal, nearly straight backwards, or forwards, or both.

Although in some cases its external part is short, yet in some of the brains of inferior type this external part is long, and there is a tendency to groove or channel the upper surface of the first external occipito-parietal annectant fold, and to run out thence on the upper cerebral surface, and into and across the interparietal sulcus, or beyond it, and perhaps far down, so as to join or cross the continuation, or a spur, of the first temporal furrow—coursing far back—or of the second.

Yet, in some of the cases in which the external being wide, the continuity of the two parts of the fissure is broken by a triumphant first occipital gyrus, we nevertheless, immediately beyond this bridge, or slightly behind it, find what is obviously the representative of the external limb of a parieto-occipital fissure (in this event discontinuous) which bears itself in the manner last described as being the course of a few continuous parieto-occipital fissures. The anterior continuation of the first occipital gyrus just described as "triumphant" is also rightly entitled to the qualification "bridging," so often misapplied to gyri, hereabouts.

But whether strictly continuous, or discontinuous, or of intermediate type in this respect, the external part of the parieto-occipital fissure is sometimes a deep irregular cleft, a bold dividing and bounding fissure, nearly straight or zig-zag in course, the walls of which present rounded elongated projections in relief, and sometimes, as well, gyri coursing athwart the chasm and deeply hidden away in it. Thus, I have seen in man the representatives of the second external annectant of the lower simian brain, which had not fully attained the surface. The chasm also sometimes leaves or bevels behind it a distinctly projecting occipital lobe which breaks the gradual even curve of the posterior declivity of the cerebrum, and very slightly reminds one of the chasm and operculum of the lower apes.

The parieto-occipital fissure is sometimes situated far back, so that the occipital lobes are short and small.

In one case, with both quadrates affected with "præcuneoli," the external limb of the parieto-occipital fissure was very short on one side, long on the other; and the posterior central gyri, temporal gyres and furrows, and interparietal sulcus, were very abnormal in conformation.

Again, a long bold inferior occipital fissure may run fore and aft almost from occipital tip to second temporal sulcus.

Other conditions apt to accompany the formation of a præcuneolus, and of a cuneolus (yet to be described), and the aberrant states of occipito-parietal frontier; concern the cuneus, other deviations of quadrate, sub-frontal fissure, fornicatus, transverse occipital sulcus, superior parietal lobule, first temporal gyrus; unusual furrows; formation of large islands of cortex.

FRONTIER MORPHOLOGY : PARIETO-OCCIPITAL FISSURE.

As a frontier element, and already touched upon, we may conveniently take, here, the parieto-occipital fissure. Besides the deviations already mentioned, such as its crossing a grooved and depressed first parieto-occipital annectant gyre, and conjoining with interparietal sulcus or its spur; the parieto-occipital fissure may present a number of deviations yet to be mentioned under other heads; and others still as, *e.g.*, the sending of a branch to parietal sulcus (of Jensen), or to sub-frontal, or joining with transverse occipital sulcus. Rarely, a more or less superficial upper internal annectant divides the fissure into two.

And, to conclude this point, we may for a moment leave the mesial surface, to follow *the external limb of the parieto-occipital fissure* on the upper surface—a subject already broached under the “associated conditions” described in the last section.

A highly marked external limb of parieto-occipital fissure, depressing the first external gyre, and passing far out on the upper hemispherical surface, is a mark of inferiority in type. It is also present in some microcephales. But whether such outward continuation (from the internal limb) represents the ape-chasm is quite another question, and in some of the higher apes the upper-edge notch of the parieto-occipital appears to be usually quite distinct from the chasm. Later on, we must consider what, in man’s brain, represents the ape-cleft; here we need only mention that the transverse occipital sulcus is by one view taken to be such representative, and in permanent form; whereas another view limits the representation of the ape-chasm to the *transitory* external perpendicular occipital sulcus, which, normally, exists only for a time during foetal life, disappearing, for good, a while before full-time birth; so that the human adult brain would show no representative of it unless by an abnormal preservation and persistence of that foetal state.

States of parieto-occipital fissure, on mesial aspect, indicating inferiority and atypy.

The following, I take to be atypic and signs of inferiority in adult man. They indicate reversion as a rule; but, as regards some of them, foetal-character persistence in certain examples. Each is present in certain ape-forms; in some

microcephales; and in some fetuses also, as regards several. They are:—

An internal limb of parieto-occipital fissure interrupted by a superficial gyrus cunei, or other annectant gyre (superior internal), which has attained the surface:—

Doubling of the internal limb of the fissure; shortness of it; failure to reach the upper border; slightness of its incision there:—

Its defective depth and boldness, *relatively to the calcarine*.

Spurs running fore and aft from the internal parieto-occipital limb, furrowing and practically expending themselves on præcuneal and cuneal surfaces; or shallowly touching the upper hemispherical edge:—

Confluence of the conjoint “stem” of calcarine and parieto-occipital with the collateral fissure. This is sometimes made (often shallowly) by a rectangular groove across a somewhat sunken retro-limbic annectant gyre.

GYRUS CUNEI.

The *gyrus cunei* is another frontier element, the superficial position of which has just now been spoken of as a departure from type and sign of inferiority.

The deviations from usual type of the gyrus cunei, or cuneo-limbic annectant, are of importance. This gyre is almost always present and deep in man; it was found absent in about 3 per cent. only, superficial in about 4 per cent. only, by Cunningham. As a rule, it is deep in gibbons, also. In other apes it is superficial.

Its structure I find to be very complex. It consists chiefly of half-round, or one-third-round, coils in relief, twisted around each other, especially as regards two such. For example, in one case, following it from its issue from the limbic region, *backwards*, I observed the two chief coils, *in basso*-, or almost *demi-relievo*, present the following turns:—The one more externally situated, and, of the two, the further away from the observer, had seemingly come from below the other, and, as one followed it backwards, was now, in relation to the other coil, successively, external; above; internal; below; and then entered the cuneus to form its lower zone, bordering on the calcarine fissure. The other half-round in relief, similarly followed, was, in relation to the first one, just the reverse, namely, in succession, internal; below; external; above; and then entered as if to form the anterior

coast of the cuneus skirting the internal parieto-occipital fissure.

The coils are not usually so much twisted as in that case, but the two chief ones seem to enter and distribute themselves as just described; one on the lower zone, the other on the anterior zone of the cuneus. A third one, further from the mesial surface, strikes in more deeply, and into the middle region of the cuneal substance. Its trophic relations may be chiefly with the upper posterior part of the cuneus. This appeared to be so in a case of mine.

In that hemisphere, there was no anterior cuneo-lingual annectant gyre, but the posterior cuneo-lingual was superficial and cut off the posterior vertical divaricating rami of the calcarine fissure, situated on the posterior occipital surface, near the mesial edge; and close thereto began a sulcus, lying on the postero-external aspect, in line with, and beginning close to, the end of the calcarine, and its forward course being on a level about opposite to that of the calcarine fissure.—Query: A persistent foetal “external calcarine” furrow?

The calcarine’s end was directed in an unusually upward and oblique line, on the surface, and crossed the edge above the occipital pole, and its *incut* was upward. The lingual lobule sent a depressed and rejoining loop into the “stem.” Depth of “stem” $\frac{7}{8}$ inch. Depth of internal parieto-occipital fissure $\frac{5}{8}$ inch; of calcarine, in front $\frac{1}{2}$ inch, behind $\frac{1}{4}$ and $\frac{3}{16}$ inch; of its cross piece, at junction, $\frac{7}{16}$ inch.

The rest of the posterior mesial surface is occipital, and may be more conveniently dealt with in the next chapter, on the Occipital Lobe.

CHAPTER IV.

OCCIPITAL LOBE (*including its Mesial Surface*).

THE CUNEUS. ITS CONDITIONS OBSERVED IN BRAINS.

In some brains it has struck me that there is a sort of inverse relation in size betwixt the quadrate lobule and the cuneus.

The cuneus may be small, it may be very irregular or twisted, it may seem to be connected by canal with the sub-frontal fissure by the intermedium of spurs running fore and aft from the parieto-occipital fissure.

In some cases, there is insulation or peninsulation of a cuneiform portion of its surface, which I term the formation

of a *cuneolus* or *posterior cuneolus*. For, occasionally, a posterior prong of a bifurcating or trifurcating internal limb of parieto-occipital fissure cuts off, or nearly so, a triangular portion of the cuneus, and chiefly its upper and anterior part.

This, too, is apt to be more or less sunken, concealed, and only to be found on loosening of the parts. For it may consist of an unusual form of the superior internal parieto-occipital annectant gyrus, and of the furrow bordering it posteriorly, which last now drives deeply into the cuneus, ploughing off the upper anterior triangular area of its surface, and, in at least some examples, amounts to a fork of the parieto-occipital fissure. In transition cases between this and the more usual and normal arrangement, the cortical area (*cuneolus*) between the forks is somewhat sunken, lying externally and laterally to the general mesial cerebral surface plane.

And occasionally an irregularly triangular upper and posterior, or upper, part of the cuneal area, along the great cleft, is furrowed off by an occipital furrow, or an unusually or aberrantly developed one, running from above nearly across the cuneus to the calcarine; or running from before backwards.

That some of the above conditions of the cuneus represent degrees of the atypic, and reversion towards lower form, seems to be clear if one reflects upon the progression in conformation from the lower simian brain, to that of the higher anthropoid apes, and to that of man.

COMMENTARY.—In high ape (chimpanzee) may also be a tendency to form a *cuneolus* by a spur from parieto-occipital fissure.

In the full-time human foetal brain (of aberrant type?) a condition resembling the formation of a *cuneolus* may be found; a continuation of the stem, or a spur of parieto-occipital fissure, cuts off, or nearly so, an upper and anterior triangular portion of the cuneal surface, and with this the superior internal annectant gyre * may become incompletely or completely superficial, and in some cases the fissure cutting off the *cuneolus* appears like an extension of the stem.

Moreover, and this is another subject, this extension of the stem may end in a bifurcation at nearly a right angle to

* This, at least, I take it to be, and not the inferior or cuneo-limbic annectant as it is figured and described to be by Cunningham, in an example of the kind.

the main trunk of the stem, and the posterior spur may partly cut off the upper irregularly triangular shaped marginal zone of the cuneus ; and by its junction with other furrows this may explain, in some cases, the cut-off there, already mentioned under "cuneolus."

In the human foetus, even in the sixth month, may be an appearance as of a spur from parieto-occipital fissure running on mesial aspect, and cutting off the upper and irregularly triangular zone of cuneus ; the second of the two conditions just mentioned.

There may be a foetal state correspondent to the condition of fore and aft forking of the parieto-occipital fissure on mesial surface, which I have already described incidentally (under *præcuneolus*). A similar fore and aft forking of parieto-occipital fissure is figured in a microcephale, by Giacomini.

As to the significance of the formation of a *cuneolus* or *posterior cuneolus*, the remarks applicable here are somewhat of the same general drift as those already made in reference to the formation of a *præcuneolus*.

CALCARINE FISSURE.—In some low-type brains, I found the calcarine fissure beginning, posteriorly, much further forward than usual, but sometimes with a short curving sulcus behind it. In this way, much of the posterior part of the calcarine had disappeared ; and there seems to be a reversion towards ape-type ; the condition being in some cases, perhaps, modified by a superficial position of the posterior cuneolinguinal annectant gyre.

The back part of the calcarine fissure absent, or slightly marked ; or in small segments separated by superficial bridging gyres ; or very jagged or zig-zag ; are, all of them, states which seem to be more or less atypic, and signs of inferiority, in man.

Confluence of the conjoint stem (of calcarine and parieto-occipital) with hippocampal fissure has been widely accepted as a mark of defective form in the human adult brain. But the evidence on this point does not tell all in one way.

A deep calcarine fissure uncrossed by sunken annectant gyrels, preponderant *relatively* to the parieto-occipital fissure, and bounding a small cuneus, indicates a retrograde condition, approximating simian type ; and is found in some small-head idiots.

For a long time, I have found convenience in adopting

the usage of the short German name *stem* ("stamm") for the conjoint continuation of the calcarine and internal parieto-occipital fissures; and it is so named in this article, and separately from the calcarine fissure between the cuneus and lingual lobule.

It has been stated that, in the calcarine fissure behind the stem, the opposing walls of the fissure are vertical, the fissure incising the cerebrum at right angles to the surface, whereas the stem cuts obliquely downward into the hemisphere; and morphological importance has been given to this in relation to the separate development of these two parts, and the different phylogenetic significance attributed to them. But I have not infrequently found the calcarine fissure, behind the stem, present a more or less obliquely downward incut, in the same direction as that of the stem, but in much less degree as a rule. Sometimes, only part of the fissure manifests this obliquity of incision into the cerebral substance. Thus, the anterior part, or half, only; or the anterior and posterior portions (say, thirds) only; may have this slanting state of the fissure-walls; the posterior half in the former case, the middle third in the latter, making a cut into the cerebrum at a right angle to the surface. In some cases the whole of the calcarine fissure shows the downward slant. As an example of this, may be mentioned the last necropsy but one I made before the writing of these lines. The calcarine cut obliquely down into the brain; and it was not a stem prolonged into the cuneus, but a perfect calcarine fissure, strongly marked, and terminating behind in a vertical furrow formed by its divaricating rami, situated on the posterior occipital aspect fully, and away from the edge marking the junction of posterior with mesial surface. The lingual lobule thus formed a slight operculum overhanging the fissure, and dominating the cuneus. The anterior cuneo-lingual annectant gyrel was *very* deeply sunken and small, the posterior one was deeply sunken. An arm of a terminal posterior cross-piece of the lingual sulcus bore somewhat into the calcarine, at the junction of the latter's posterior and middle thirds, carrying before it an arc of lingual cortex. The long collateral fissure ran to about the occipital tip, and to within $\frac{1}{16}$ inch of the calcarine fissure; it was otherwise unusual. The gyrus cunei was very intricate; the upper internal parieto-occipital annectant was very noticeable, one half-round, in relief, coming from parietal side and inserting itself between two such from upper

anterior angle of cuneus. On sounding the depth of the fissures, the following measurements were obtained :—Internal parieto-occipital fissure $\frac{5}{8}$ inch at deepest part ; $\frac{9}{16}$ inch near upper hemispherical edge : stem $\frac{9}{16}$; calcarine fissure $\frac{1}{2}$ inch, both just behind the anterior cuneo-lingual anastomosing gyrel and just in front of the posterior one. The brain was irregular and defective in conformation in several respects.

While this *downward* incut of the calcarine fissure is not infrequent in inferior brains, the middle or posterior third occasionally has an *upward* incut.

Occasionally, the posterior part of the calcarine, behind the posterior cuneo-lingual anastomosing gyrel, is the deepest part of the fissure ; as in one of my degenerate cases in which that part had a depth of $\frac{5}{8}$ inch, the deepest other point being $\frac{1}{2}$ inch. In the other hemisphere of the same brain the posterior part of the fissure was also the deeper. In another case the anterior part of the calcarine had a depth of $\frac{7}{16}$ inch ; the posterior part, of $\frac{9}{16}$ inch. In another, the anterior part of the calcarine was $\frac{7}{16}$ inch deep ; its posterior terminal divaricating rami were at deepest, $\frac{9}{16}$ inch in depth. This last was in a left hemisphere ; in the right one, of the same brain, the anterior part of the calcarine was $\frac{7}{16}$ inch deep, the posterior only $\frac{6}{16}$; and, differently from that of the other side, ended in a single simple spur, posteriorly. It will be borne in mind that the "stem" is not being included here ; but for convenience is spoken of separately.

My experience does not coincide with that of Sernow as to division of the calcarine into two being rare (unless, indeed, we leave its terminal rami out of view) ; and as to shortness of calcarine being in some cases from defect of its anterior section (except in so far as may be due to a rise of the anterior cuneo-lingual to the surface).

In a number of cases, there appears to be an inverse relation between the size, development, and position of the gyrus cunei and the anterior cuneo-lingual anastomosing gyre, of such kind as that when one of them is comparatively large, well-developed, and superficial, the other is smaller, more deeply sunken than usual, or even absent, or nearly so. But in some other cases this inverse relationship fails.

The *anterior* cuneo-lingual anastomosing gyrel may be set further back than usual, the *posterior* one further for-

ward. And, either with or without this relative shifting, there may be three cuneo-lingual anastomosing gyrels grouped more or less closely together. These dispositions are apt to exist in some of the cases in which the posterior part of the calcarine—or its terminal forking—is deeper than is the anterior half of the fissure.

An unusually far-back position of the anterior cuneo-lingual anastomosing gyrel, especially if with downward incut of the calcarine, shows inferiority, and an approach to the ape form.

Likewise, a far-back posterior cuneo-lingual gyrel, only cutting off the posterior rami of the fissure, which are sometimes deep, denotes inferiority. (Moreover, Cunningham found this form more frequent in human foetus and in adult negro, than in adult white.)

Inferiority may also be indicated by the termination of the calcarine behind, in a single simple unbranched end. One must dissent from Sernow's statement, if the abstract from his work in Russian is correct, that such a posterior end is usual. A contrasting, rare, deviation consists of a calcarine with two posterior bifurcations and pairs of rami.

In connection with the stem and calcarine it is desirable to refer briefly to the *collateral fissure*, although the latter is outside the scope of the present article.

Concerning *the confluence of the stem and collateral fissure* on inferior cerebral surface: in human foetal brains the middle piece of the collateral fissure (it begins in two or three pieces) is sometimes connected with the stem, and has then a more or less transverse direction, is the only part of the collateral fissure which is a complete or total fissure, for it, alone, occasions a fissure-girding fold which ever forms an *eminencia collateralis* on the intra-ventricular aspect, if and when that eminence is of fissural origin. But, as long well known,* this eminence is not always present in man; the collateral fissure is constant. The connection between stem and collateral may be seen in some foetal brains in the sixth or seventh month. Cunningham† quotes Seitz's observation of this connection in the left hemisphere of an adult male Fuegian. When present in the human adult, I find it is usually made by a somewhat shallow, or not very deep furrow, grooving the retro-limbic annectant gyre, and crossing from the conjoint stem, rarely

* Jung, cited by Ecker.

† *Memoir*, 1892, p. 72.

from the "posterior" calcarine, to the collateral, at about a right angle to both; somewhat like the arm or piece rectangularly joining a bayonet-blade to the musket-barrel.

It is always, or at least usually, an element in the formation of the girdle of furrows, *fissure-girdle*, which I have observed, and have described above, in Chapters II. and I.

It may represent abnormal persistence of an inconstant and transitory foetal state.

In some brains of a low order or aberrant type, I have found two apparently contrasting states of the collateral fissure; for in some it is defectively developed, broken up into separate scattered representative fragments; whereas in others it is long, bold, and coursing on the inferior occipito-temporal region almost from tip to tip of the two lobes. The former state of the fissure seems to indicate arrested development; the latter, reversion in form.

The collateral fissure may quite differ in depth in the two hemispheres of the brain.

In a brain of aberrant form, it may skirt along the coast of a relatively narrow gyrus hippocampi and end, behind, very close to the posterior end of the calcarine fissure.

It may terminate behind in a cross-piece formed by its divaricating rami, on the postero-mesial aspect, just below, and at right angles to, the calcarine vertical terminal cross-piece; therewith, the sulci on upper parieto-occipital region being also very irregular and complicate or duplicate.

TRANSVERSE OCCIPITAL SULCUS.

The transverse occipital sulcus may run close and parallel to the outer limb of the parieto-occipital fissure, only separated from it by a thin gyral fold or ridge.

Its outer end may receive the conjoint and sometimes much-curved furrow formed by the meeting of the parieto-occipital fissure and inter-parietal sulcus; and the sulcus may curve mesially to, and on, the cuneal surface, not far from the upper border. (See "Cuneus" for discussion of some of these conditions).

Or the transverse occipital sulcus may run a little distance outwardly and downwardly on the superior cerebral aspect, and then curve slightly forward and join with the external limb, or continuation, of the parieto-occipital fissure. It may be cut off from the inter-parietal sulcus. It may zig-zag outwards and forwards.

Other things equal, its unusual nearness to the external limb of the parieto-occipital fissure, in their somewhat parallel course, or separation only by a narrow ridge, seems to mark a defect in the advance of the human on the simian brain just thereabouts—if the homology of Ecker be accepted. And its junction with the external limb, or continuation, of parieto-occipital fissure, occasionally seen, appears to have much the same significance. This junction is also effected in some idiot brains.

Theories on the transverse occipital sulcus (of Ecker).

The sulcus occipitalis transversus of Ecker was by him identified with the fissura occipitalis externa of Pansch, and with the fissura occipitalis perpendicularis externa of Bischoff.

The two chief views on the nature of the sulcus named transverse occipital by Ecker, as found in human adults, are as follow:—

I. That in man it represents the ape-cleft (or an element of the latter) which demarcates the simian occipital operculum in front (\therefore , = “affenspalte”).

II. That it is a dependency—in fact the posterior bifurcation and rami—of the occipital portion of the interparietal sulcus, and is quite independent of the ape-cleft proper.

In support of the latter, Cunningham adduces the state of furrows found in one hemisphere of a new-born child, which he takes to mean the co-existence of representatives of the transverse occipital sulcus and of the “affenspalte” in that instance.

Besides those who openly assert the identity of the two, Broca, as the “external occipital fissure” (using the name in a sense equivalent to external, or superior, or horizontal limb of parieto-occipital fissure), describes what is evidently, although he does not mention it, the transverse occipital sulcus of Ecker.

Its inner end starting in the concavity formed by the occipital meander of the first external parieto-occipital annectant gyre, this external occipital fissure is continued at least as an incision received in a curving fold of the second external annectant. This sulcus extends outwards on the cerebral convexity to an extent varying with the depth of the incision continuing it into the second external annectant, and with the extent of the depressed grooving which may occur on that annectant, and beyond it laterally.

As a rule, the occipital meander of the first external annectant separates the fissure in question from, and thrusts it behind, the notch of the *internal* occipital fissure in the upper hemispherical border. But if that meander be locally depressed, the external part of the parieto-occipital fissure becomes directly continuous with the internal part or limb as in most apes and also in some human brains. As in the first case, so also in this, the sulcus extends outwards on the upper surface to an extent varying with the length and depth of the incision continuing it into the occipital insertion of the second external annectant gyrus, and with such depressed grooving as may occur on this gyrus, and on gyres beyond it, laterally; so that this form of the external occipital fissure occasionally becomes long and far-reaching.

A distinct well-marked formation of this "external occipital fissure," Broca attributed to the convexities of the meanders of the two upper external annectant gyres being set back to back. But now let them develop in a position shifted from that of being set back to back, and so that the convexities of the one correspond more or less with the concavities of the other in the parietal and occipital meanders of the two gyres; then, more or less, also, the meanders become mere flexuosities, the inter-parietal sulcus seems to be continued far back on the occipital lobe between these two upper (and, here, occipital) gyres; the notches on their confronting borders cease to be directly opposite to each other; and, having thus lost their confronting position, their typical transverse direction, and their usual depth, they become difficult of recognition.

Representation of Ape-chasm in Human Brain.

Is the ape-cleft represented in the brain of the human adult?

If it is, is it represented by the transverse occipital sulcus (of Ecker) ?

Or is the representation made by the more less shallow, direct continuation from the internal parieto-occipital occasionally found on the superior, or superior and lateral, aspect of the hemisphere ?

Or is its homologue the anterior occipital fissure (of Wernicke) ?

Or is it represented, in normal conditions, only by the foetal and temporary sulcus of Bischoff ?

And if the sulcus of Bischoff is, normally, in the human subject, only a foetal furrow which disappears for good and leaves no vestige after birth, does it ever persist as an abnormality in adult life? And if so, in what form and position?

There are a number of brains which have occipital fissural elements possibly representing such persistence. I incline to think the occipital furrows to have been hitherto imperfectly described, and that Ecker's description and figures of his sulcus occipitalis transversus may refer to, and include, two inconstant furrows, each of which, in different cases, as the one or the other predominated, might be taken to be the transverse occipital sulcus. Anatomists seem to differ in their recognition of this sulcus. Indeed, there are in some brains two furrows, either of which might be taken as the sulcus of Ecker; in others only one.

Sometimes on the upper occipital surface there are even three (or four?) more or less transverse furrows (quite irrespective of, and behind, the parieto-occipital fissure and any *direct* continuation of it). One of these may represent a persistent sulcus of Bischoff. The following are examples of the kind which happen to be in the brains most conveniently at hand:—

1. In the first: The parieto-occipital fissure was directly continued somewhat shallowly over a depressed first external annectant gyre. The interparietal sulcus debouched into a short transverse occipital sulcus, immediately behind which the line of the interparietal sulcus, as interoccipital sulcus, was continued over, and backward beyond, a well-marked deep gyrel. Behind and nearly parallel to the transverse occipital sulcus, but directed slightly backward in its outward course, a sulcus ran transversely outward; across, and some distance beyond, the inter-occipital sulcus, and nearly to what was taken to be a very irregular inferior occipital sulcus. Inwards, the sulcus under description ran over a depressed grooved edge of the first occipital gyre—at a point about the middle of the antero-posterior diameter of the cuneus—to the mesial surface, where it entered a longitudinal cuneal sulcus, which nearly cut off a narrow marginal cuneal tract bordering on its upper edge. The posterior wall of the long transverse sulcus overlapped the anterior wall, forming a small but distinct operculum. The first occipital gyre was wide, and was somewhat sunken on its upper surface between the parieto-occipital fissure and the operculified sulcus just described.

2. In the second: Shortly behind the parieto-occipital notch the interparietal sulcus entered a distinct transverse occipital sulcus. The outer of the two divaricating rami of the latter was partly separated by a deep crossing little gyre from the point of division of a furrow behind it, consisting solely of two rami, one downward and outward, the other inward and slightly forward, and ending very close to, and being perhaps practically a continuation of the outer end of the anterior of two transverse and parallel little furrows, connected at their middle by a third sulcus, the three being like a letter H reposing crosswise on the hemispherical edge, and sending down the two inner ends on the mesial surface, between which ends a long spur from a sagittal intra-cuneal sulcus rose nearly to the upper hemispherical edge. The hinder of the two main limbs of the H-shaped sulcus was overhung by its slightly opercular posterior wall. The condition seemed somewhat similar to that of the first case, but with a very irregular and reduplicated form of the sulcus trending on the mesial aspect.

Still further back, beginning very close to, and on a level with the calcarine, was a sulcus in the position of a persistent foetal "external calcarine fissure."

3. A third hemisphere, shortly behind the parieto-occipital fissure, showed a partly interrupted, oblique, and curving sulcus (transverse occipital sulcus?), crossing the inter-occipital sulcus. Behind that former sulcus was another transversely-set one, running obliquely from mesial aspect, near the internal parieto-occipital fissure, nearly cutting off an upper and anterior triangle of cuneus, and then out on upper surface, being separated from the inter-occipital sulcus by a slender gyral fold, and showing a deep little gyre sunken in its course. The posterior rami of inter-occipital, far back, ran, one to near occipital tip, the other to inferior occipital sulcus. The outer edge of the wide first occipital gyre was overhung by the opercular-edged second gyre.

4. In a fourth the general arrangement was somewhat as in the first, but the sulcus coursing over on to the cuneus, and there entering at a right angle into a high-placed longitudinal cuneal furrow, did not, in this hemisphere, on the external aspect, reach the inter-occipital sulcus (which last was irregular and interrupted by somewhat sunken gyrels). Behind the former another transversely-placed sulcus was shallowly confluent with the inter-occipital, over sunken gyrels, and its posterior wall was slightly opercular.

All the above four were *right* hemispheres.

5. In the *left* hemisphere of the second case above, the interparietal's "occipital ramus," after giving off a spur bordering the annectant just behind the external limb of parieto-occipital, continued straight backward into a terminal transverse sulcus or cross-piece. Between the spur and cross-piece just mentioned a sulcus began, ran thence obliquely backward and inward, crossed the border, passed down and back on mesial surface, nearly cutting off a narrow posterior and upper triangle of cuneal surface.

But behind the cross-piece already mentioned a *bold sulcus overhung opercularly from behind*, ran, from just at the upper hemispherical edge, downward and slightly forward; being set far back on the external arch of the cerebrum, and entered an antero-posterior sulcus below, and nearly at the point of junction therewith threw off two backward spurs, of which one was also somewhat upward, the other also obliquely downward.

This bold sulcus may represent a persistent foetal external perpendicular occipital sulcus (of Bischoff).

In a sixth hemisphere were two transversely-set occipital sulci connected with inter-occipital apparent continuation of inter-parietal. The gyral fold between them was opercular forwards.

Sernow seems to have been baffled by the inconstancy in number, the varieties in direction, and the failures in appearance of the transversely-set occipital furrows.

OCIPITAL OPERCULUM.

Tendency to an appearance slightly resembling the simian occipital operculum indicates a tendency to reversion towards that form, which only needs mention.

REVERSED OCCIPITAL OPERCULUM, OR POSTERIOR PARIETAL OPERCULUM.

In this formation, the simian occipital opercular type is reversed, and the occipital lobe takes on, somewhat or slightly, the aspect of a buttress, a sort of curved abutment, under the beetling brow and backward crest of the parietal. With this, the first occipital gyre tends more or less to be depressed in front by a branch, or by the main trunk of the parieto-occipital fissure.

The more vigorously developed parietal lobe projects a

little backward, and slightly overhangs the occipital, forming a little operculum as an indication of domination.

This "reversed occipital operculum" (as I ventured to call it)—or little parietal operculum—is a deviation from the accepted form, which I observed a number of years ago. I think it may be taken as an unusual condition when it is extremely marked, but in the direction of lack of balance as being due to a mode of formative activity tending to high evolutionary type, but somewhat overdone, as the manifestation of an over-activity on the more important line of evolutionary advance, with some *relative defect of activity* on the (occipital) line which, normally, should offer a due and appropriate measure of resistance to the one which has become predominant, at the point in the animal scale represented by the brain of modern civilised mankind. It may be taken to be the lower part of the parietal lobe to which these statements are more especially applicable.

If the above is correct "the reversed occipital operculum," or posterior parietal operculum, so far as it goes, signifies something of high type, yet associated with impaired balance, with defective occipital ontological formative activity and phylogenetic endowment.

The cases with this form had more or less of the impress of hereditary mental degeneracy, with elements either of imbecility or of paranoia.

OCCIPITAL GYRES AND SULCI AND LOBES GENERALLY.

It is now time to say some words on the occipital lobes and their constituents, from a general point of view.

In a few cases I found an appearance as of five long, narrow, superimposed tiers of gyri showing on the mesial aspect of the occipital lobe, owing to unusually bold definition of intragyral sulci, or to other fissural states.

In a few the superior or inter-occipital sulcus, or its apparent representative, was extremely irregular, or exaggerated, or both.

The first occipital gyrus may curve mesially and yet bridge the parieto-occipital fissure.

I have found atrophy of the first occipital gyre, partly compensated by a vigorous second one, possessed of very flexuous bold meanders.

In some brains the noticeably divergent occipital lobes leave the cerebellum very defectively covered behind.

Relative smallness of occipital gyri may be a mark-worthy

feature, for in some brains of inferior type I have observed a somewhat smaller *relative* size of the occipital lobe, at least as gauged by antero-posterior measurement, *i.e.*, a *relative* smallness of the part of the measurement—or relative index—from parieto-occipital fissure to occipital tip.

At first sight this may seem to be discomposing, in face of the usually accepted views which would implicitly teach that *relative* largeness of occipital lobes, and not relative smallness, would indicate inferiority in type (other things being equal).

Thus Rudolf Wagner long ago taught that there is a *relatively* longer antero-posterior diameter, from parieto-occipital fissure to occipital pole, in common labourers and in the orang than in learned men, in some of whom last it was only one-sixth of the total; and that in the former the occipital convolutions are comparatively few and simple.

And let us speak of the measurements along the upper border of the frontal, or parietal, or occipital lobes, as compared with the total length of the hemisphere from “frontal point” to “occipital point” along that border—this total length being taken as 100, and as a standard of comparison—whereby the *relative* occipital length, or “occipital index,” is ascertained, and by means of which the *relative* length of the occipital lobes may be estimated in brains of different animals. This *occipital index* has been stated by Cunningham to be, in human adults, both sexes conjointly, 21·2; being in males 20·8, in females 21·7. In apes it is greater than in man, as an old fact in comparative anatomy, being a little greater in anthropoids than in man, and very much greater in the lower apes, particularly in those of inferior status among these last. The same observer states the *relative length of the occipital lobe* (measured from level of parieto-occipital fissure on upper border, and compared with the total hemispherical length along upper border, measured as above described, and taken as 100) to be in

Orang	...	...	...	23·2
Chimpanzee	...	...	...	24·2
Hamadryas	...	...	...	29·5
Cynocephalus	...	...	...	29·7
Mangaby	...	...	...	30·5
Macaque...	...	...	...	31·
Cercopithecus	...	...	...	32·9
Cebus	...	...	...	33·1

And he emphasises this aspect of the subject by citation and exemplification as follows:—"Gratiolet was well aware of the great distinction which exists between man and the apes in the relative length of the occipital lobes. He states that in man this lobe is extremely reduced; and he formulates the law that the more highly organised a member of the group is, the smaller is the relative size of the occipital lobes. The truth of this is at once seen by placing the occipital indices of the cynocephalus, orang, and man in opposition with each other.

OCCIPITAL INDICES.

Cynocephalus 29·7, Orang 23·2, Man 21·2."

It has long been well known that (of the several lobes) the *relative* antero-posterior length of the occipital lobe is greater in the anthropoid ape than in man, in the lower ape than in the higher. And Cunningham finds in the human subject the *average relative* occipital length slightly greater in female than in male, and increasing during the eighth and ninth months of foetal life by about 10 per cent. above its length in the sixth and seventh months, but apparently having its greatest *relative* length between birth and the age of four or five years. He cites Eberstaller's views to the effect that there is a relatively greater size of first parieto-occipital annectant gyre in female than in male, and great relative size in chimpanzee and orang; and that a far out-turn of the (external) parieto-occipital fissure, and of its arched bordering gyrus, marks the anthropoid-ape-like character, and shows developmental inferiority.

But if we examine the brains of microcephales we find in some, even of those who have survived to adult life, that the occipital lobes are often decidedly shortened relatively to the entire hemispherical length, or even if of good *relative* antero-posterior length (*i.e.*, parieto-occipital fissure to occipital tip), yet are curtailed in dimension and thin from above downwards, fail to fully or normally cover the cerebellum posteriorly, and look as if the lower part of the occipital lobes is deficient or small, and as if these lobes are thrust up by a high-rising cerebellum. And irrespectively of cases like this, the *relative* size of some occipital lobes in what I term *microcephaloid* conditions seems to me to be smaller than normal.

My observations of brains on this point were made without the least reference to any view or theory, and I am reassured

as to their accuracy by the reflection that the general trend of researches made of late years goes to confirm, *as regards certain points*, the conclusions of Rudolf Wagner, who, so long ago (at least) as about 1860-2,* expressed himself to the following effect, namely :—

Microcephaly pertains partly to a developmental arrest of the posterior lobes of the cerebrum, and seems to commence in the third and fourth months of embryonic life.

Probably in all these malformations the part primarily affected by morbid change (“*erkrankte*”) is never the skull but always the brain.

Between the constant form of the gyri of cerebral hemispheres in the brain of apes and that of those of the earlier developmental stages of the brain of the human embryo, a parallel can be shown. . . .

These conclusions were independent of others he arrived at on the general subject, and we may still adhere to them without committing ourselves to other views he entertained.

The bearing of this view of microcephaly on the matter at present under discussion is obvious. For many of the subjects of hereditary mental degeneracy, such as some of those whose brains I examined, are in reality of *microcephaloid type*. Between the microcephalic idiot and the person of normal psycho-somatic formation there is not an impassable gulf; there is not a gap representing a host of missing links, and only to be crossed by a vaulting leap of imagination. Between them there is every possible grade, a long connected series of intervening states of increasing deviation, ranging from the highest exemplar of the normal to the idiot microcephale.

And although we may not tarry by the way, assertion, here and now, of the supreme value, in these studies, of the *microcephaloid type* and conditions is what I desire to drive home with full force.

Therefore relative smallness of occipital lobes, defective development of them, undue retention of foetal characters by them, reversion to lower animal form manifest in their morphology; all are valid indications of deterioration and inferiority.

* Vorstudien zu einer wissenschaftlichen Morph. u. Phys. des menschlichen Gehirns als Seelenorgan. Göttingen, 1860-62.

*Occipital-brain development in relation to mental status—
continued.*

We may now further briefly refer to the question of the relative degree of development and preponderance, or the reverse, of occipital lobe and gyres, as bearing on the mental status of the individual or of the race.

It has been held by some that certain occipital gyri are of great importance in this respect. And, for the sake of conciseness, we may now briefly refer to the first occipital gyre and its anterior annectant fold, inasmuch as upon what may be established regarding *it* depends the fate of several views, whether to stand or to fall, or to require modification or counterpoise.

To begin with, the first occipital gyrus (with external parieto-occipital annectant) has been stated to be relatively much developed in man; and to be smaller, more simple, and less developed in negro than in white, in idiots than in normal persons, and to be far less marked in higher apes than in man; while, for practical purposes, it is slight or absent in lower apes, although this is not to deny that these last may possess a non-identifiable representative of it.

In the annectant gyri, or some of them, as well as in the occipital lobes generally, ape-like characters have been claimed for some criminals' brains, and examples of small defective occipital gyres have been recorded in some idiots, paranoiacs, and moral perverts. And it has been found in some cases that what first seemed to be a richly convoluted occipital lobe of high type has turned out, on further examination, to have a non-typical aberrant conformation of gyri and sulci, and a morbid state of local microgyria.

Rudinger carried to an extreme the view as to the predominant importance of the first occipital gyre, or first external parieto-occipital annectant. He stated that it increases in size from lower apes to primates, and so on through females to greatest fulness in males who are well-endowed mentally; and that its greater degrees of development lessen the curve of the interparietal sulcus, and so make it more straitly anterior-posterior, more sagittal, in direction, or less oblique.

These assertions have been much shaken and, at least in part, successfully controverted by Cunningham, who found the interparietal sulcus in human brains to have, on the average, a greater interparietal angle, and therefore a greater

obliquity in males than in females, in adults than in foetuses. The method of ascertainment of this may be open to improvement, however. And the greater relative length of the sagittal part of the interparietal sulcus in foetus than in adult does not seem to entirely harmonise with these conclusions.

Nevertheless, as regards its relative size, development, form, position and relations, the possession of considerable importance by the first external parieto-occipital annectant gyre remains unshaken, its human characters mark a triumph in the evolutionary struggle; a triumph which probably was a necessary step in the attainment of man's supremacy, and they remain as the stable fruit and possession of victory. Yet it may well be (as I think is the case) that this gain must now yield in immediate direct value to the evolutionary changes effected in some other parts, and that, among these last, the developmental and evolutionary advance of the representative of the second external parieto-occipital annectant gyre, and of the inferior parietal lobule in man, may mark an even greater, or at least later, triumph, and be of more supreme latter-day importance. And this is quite compatible with what we seem to find elsewhere; for example is quite consistent with the enormous importance of the evolutionary advance of the lower part of the *frontal* lobe in man as compared with other animals, in the human adult as compared with the foetus. For from amidst all the conflicting evidence on this subject, relevant to the frontal lobe, there stands out the fact of the enormous opercular growth around the insula and various other frontal changes in man, leading, *inter alia*, to complete submergence of the island in normal adult brains. And somewhat like as this view does not detract from the value of recent evolutionary advance stamped on the uppermost frontal gyre; advance which seems to be not only one of the most recent gains of the human brain, but to be even now undergoing increase and tending to incipient firmness of establishment and fixation, so to speak; so, also, with regard to the upper occipital and the lower parietal regions, the value of the advance in the one is not contravened by the importance of the progression in the other: nor should the lustre of the older triumph be paled by the splendour of the newer.

(To be continued.)

CLINICAL NOTES AND CASES.

A Case of Tumour of the Brain. By FLETCHER BEACH, M.B., F.R.C.P., formerly Medical Superintendent, Darenth Asylum.

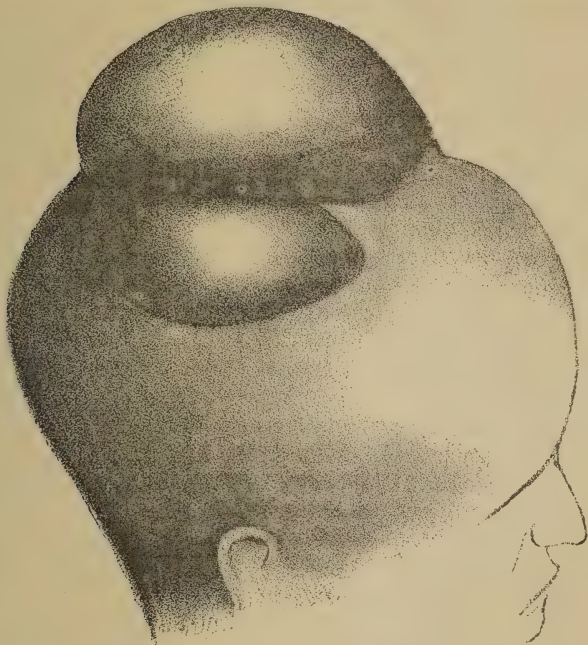
A. T., aged six years, was admitted into Darenth Asylum, October 26th, 1882, with the following history:—The patient was born at full time, but his mother had a difficult labour and instruments were required. At birth, the head was misshapen, and about a month afterwards a lump the size of a walnut formed, which was tapped twice and a small quantity of fluid withdrawn. When two years old he was run over, and afterwards the lump increased in size; it was tapped several times, clear fluid being drawn off. After the accident he was insensible for six hours, and on consciousness being restored, he was found to have lost the use of his right arm, the use of which has never returned. Afterwards he had fits, which have continued ever since. When five years old he would stand on his head and laugh and dance. Lately he has been strange in his manner, sometimes being noisy and boisterous, at others morose and depressed. The mental deficiency for which he was admitted is supposed to be due to the use of instruments at his birth, and to his being run over.

I may here say that from histories which I have obtained, I find that the use of instruments is a much less frequent cause of idiocy and imbecility than tedious labour. Prolonged labour and asphyxia of the child are fairly common causes, and both of them were present in this case.

The father had died of phthisis, and there was a history of paralysis in the family. The parents had both been temperate and were not connected by consanguinity. This was the third child. Of the two elder children, one suffered from spinal disease, the other was healthy. Three younger children had died of bronchitis.

On admission A. T. was found to be a well-nourished boy, of fair complexion, with irregular contour of head caused by a tumour. It was two-lobed, large, smooth and globular, giving an elastic resistancy to pressure, and apparently contained fluid. The scalp covering it was overgrown with hair. At all parts it came by its base in direct continuity

with the cranial bones, except at a part corresponding to the upper margin of the left frontal bone, where there was felt a soft depression, about $\frac{1}{2}$ inch in width by 1 inch in length, between the bony margin, which was very distinctly felt, and the base of the tumour. One lobe was larger than the other, the right measuring 4 inches and the left 7 inches antero-posteriorly. At the posterior margin in the median line there was a receding portion, into which the



TUMOUR OF BRAIN (Drawing reduced to half size), DR. FLETCHER BEACH.

tip of a finger would fit. The cranial surface was irregular and lumpy.

The head was of fair size, measuring in circumference 20 inches; width of forehead $3\frac{3}{4}$ inches. There was bulging of the right side of the nose, nearly occluding the anterior nares. The gait was awkward and weak, there being stiffness of the right leg and right talipes equinus. There was paresis of the right arm with wrist drop, fingers flexed at varying angles and thumb usually folded into the palm. His speech was slow but good, though he sometimes forgot what he was about to say. The pulse was normal. He

suffered much from epileptic fits. He was vacant in appearance, though sometimes he would become bright and cheerful, at others bad-tempered. His mental capacity was small, and though his observation was good and imitation and attention fair, his memory was very defective. He could not read or write, but would spell two or three words, add 2 and 2, and count to 50.

In December, 1883, the tumour was again examined and the following measurements taken:—

Right lobe, antero-posteriorly, $5\frac{1}{4}$ in. ; transversely, $3\frac{1}{4}$ in.

Left lobe, " " 7 in. ; " $5\frac{1}{2}$ in.

Line of junction between the two lobes antero-posteriorly, 5 in.

The right hand was usually firmly closed, with the index and middle fingers flexed tightly over the thumb. It was only occasionally and with very great effort that the patient could manage to open out the fingers of his right hand ; he could do so with less effort by bringing his left hand into use. To all appearance he had no power whatever over the thumb of the right hand, though on two or three occasions, after long continued and very great effort, the thumb was seen to move from the palm of this hand. The right leg was now almost firmly flexed, but he was just able with effort to put the foot to the ground. The patellar reflex of this leg was but faintly marked. Epileptic fits still continued.

In January, 1884, the tumour was again examined, when the measurements were—

Right lobe, antero-posteriorly, $4\frac{7}{8}$ in. ; transversely, $2\frac{1}{2}$ in.

Left lobe, " " 7 in. ; " $5\frac{1}{4}$ in.

The patient at this time was unable to put his foot to the ground. During the next twelve months he had repeated epileptic fits and he finally died exhausted after a series of them on January 30th, 1885.

The autopsy was made 24 hours after death. The body was fairly nourished, the right forearm contracted at right angles to the arm and the right leg drawn up. The swellings on the head, which formerly had a division between them, had now merged into one, and the depression between them no longer existed. The tumour measured across its widest part $6\frac{1}{4}$ inches—the left, larger portion, measured $6\frac{1}{4}$ inches antero-posteriorly, and the right, smaller part, 3 inches in the same direction.

The scalp was carefully dissected from the tumour, to

which it was very adherent, and on cutting into it it was found to be filled with reddish brown material of cheesy consistence. The tumour overlapped the calvaria, to which it was attached by a whitish substance of almost cartilaginous hardness, and anteriorly was connected with the brain through a hole in the skull, the size of a half-crown piece, but oval in shape. Depressions in the convex surface of the skull could be plainly seen, corresponding with the size, shape, and position of the tumour. The brain was put aside in spirit to preserve it for further examination, but unfortunately, owing to pressure of work, was neglected, so that I am unable to state the nature of the tumour. Although the case is thus incomplete, yet I have thought it sufficiently rare to place on record.

A Case of Mental Stupor : Recovery after Six Years' Duration.

By R. D. HOTCHKIS, M.A., M.B., Assistant Physician,
Royal Asylum, Gartnavel, Glasgow.

P. M., belonging to the City Parish, was admitted into the Glasgow Royal Asylum on 19th January, 1888, aged 38, married, an iron grinder.

Past History.—Unimportant. He has always been a sober man, of cheerful disposition, and fond of reading. He is a Roman Catholic, and regular in religious duties.

Family History.—No hereditary predisposition known.

Present Illness.—This began three weeks ago, and dates from the New Year holidays. During that time there were a great many religious meetings in connection with the Pope's jubilee, and he devoted his whole time to them. Thereafter he became dull and depressed, and would hardly speak except on religious subjects. He also neglected his home and his personal appearance, and began to spend money recklessly. At the end of the holidays he refused to go back to work, giving as his reason that God would provide for his family. If left undisturbed he would pray for hours at a time.

On admission he was depressed, and would not answer a single question. In appearance he is a slightly built man, in an apparently reduced condition. His heart and lungs are normal, as are also the reflexes.

About five days after admission he began to answer questions freely and fairly sensibly. His reason for not speaking before was that though he knew what was said to him he had not power to answer, though willing enough to do so.

February 26th, 1888.—For the last month he has been talking and acting rather foolishly. One night he got out of bed and

accused another patient of having stolen his watch 13 years ago. He said that God told him in a vision that this was the man that he is guided in his movements by the birds.

March 24th.—He stated to his wife that God had told him not to speak or eat any more.

March 31st.—He has not spoken for a week, nor has he taken any food. Fed by the stomach tube.

August 9th.—During the past four months he has been in bed in a condition of deep stupor; fed regularly with the stomach tube. To-day, however, he allowed himself to be fed with the spoon, and this was continued till May, 1889.

During these nine months he gradually lost flesh. There was always difficulty in feeding him with the spoon, and at last it became almost impossible, so that the stomach tube had to be resorted to again in May, 1889.

In July, 1889, massage was tried, but had to be given up owing to some synovitis of the knee joints. During this treatment he seemed somewhat brighter.

December, 1890.—During the past year and a half there has been no change in his condition, except that he is not quite so thin. He lies in bed with his head slightly raised and not resting on the pillow, due to tonic contraction of the muscles of the neck. His abdominal muscles are also somewhat rigid, while the muscles of the limbs are in a state of passive resistiveness. His expression is dull and vacant, in fact expressionless, and his eyelids generally are slightly open, his pupils being dilated. There is no marked coldness of the extremities. Both deep and superficial reflexes respond feebly; the fauces are insensitive, and there is no reflex action on the passage of the tube. Nothing produces an apparent impression on him. One day another patient struck him a violent blow on the head producing a deep cut, but he never moved or gave any sign of consciousness. His habits are cleanly, and he does not either wet or dirty himself. He was fed at first three times, but latterly only twice, daily on eggs, milk, biscuits, beef-tea, and porter. He is kept warm by suitable clothing.

December, 1891.—For the past few months there has been noticed slight reflex movements, *e.g.*, passage of the tube makes his jaws close, and tickling the soles of his feet causes his legs to be distinctly moved and drawn up a little. His arms sometimes move in a rhythmical fashion. Lately he was visited by two of his brothers, and they spoke in his presence of the struggles his wife was having to support his family. This caused his eyes to fill with tears, but he neither spoke nor attempted to speak.

April, 1892.—If food is put into his mouth he expels it. Other kinds of sensory stimulation, however, have not much effect on him, *e.g.*, strong ammonia held under his nose produces no effect; nitrite of amyl only causes marked flushing of the face, and increases the pulse rate.

November 3rd. —A few days ago it was noticed that he resisted the passage of the tube, and tried to expel it. Soon afterwards he allowed himself to be fed with the spoon. For the last few nights he has been restless, and talking quietly to himself and laughing. This morning when asked how he was he replied "Fine," and said he wished to put on his clothes. When asked how long it was since he had them on, he replied "Three or four thousand years."

November 23rd.—Spoon feeding continued. He answers questions in a very low voice, but does not make any attempt to get up, and everything still has to be done for him. He has been gaining weight.

December.—During this month he passed through a very severe attack of gastro-enteritis followed by erysipelas. He was very ill, and had to be fed by the rectum. His mental condition was then a little more clouded.

March, 1893.—During the past three months his condition has been variable. As a rule he is very resistive, and can hardly be spoonfed, but he is got up every day, and the interrupted current is applied regularly, with some slight beneficial effect, which, however, is temporary. A short time ago he had another attack of erysipelas. During this attack he brightened up considerably, and began to speak, expressing himself fairly sensibly. He complained about his food, and said it did not agree with him; which was quite true. His remedy, however, was to take none. This favourable state of mind lasted a few days, and as the erysipelatous rash faded he gradually relapsed.

October.—During the last six months there has been practically no change. He is spoonfed and got up every day, but hardly ever speaks. When his children visit him he takes no notice of them. His wife died some time ago, and that made no impression. He is pale and flabby.

December.—During the past few weeks he has gradually improved. First he did not require to be spoonfed. He also looked brighter, and talked in a very low voice. This was the beginning of final and permanent improvement. By the end of this month he could not only feed himself but also dress himself and walk about a little.

January 13th, 1894.—He continues to improve, and yesterday went out for the first time. He takes rather a gloomy view of his case, and says he does not think he will get well in Gartnavel, as it is not religious enough.

February 28th.—He is now much stronger physically, and is quite cheerful, readily entering into conversation and originating remarks himself.

April 28th.—Left to-day recovered. He has not gained much in weight, but seems in good average health and condition.

Mentally he has completely recovered, though there remain what are probably perverted recollections of his mental states

during his illness. His intellect is clear and unclouded, and he talks rationally and sensibly. His memory is clear about the events in his life before his illness. He has sustained no loss of natural affection, but is as fond of his children as ever. He takes an interest in political matters, and expresses surprise at the changes that have taken place during his illness.

The first point about this case is the *form of mental stupor* under which the patient laboured. He has now a confused recollection of his immediate surroundings during his illness. He remembers the doctors and some of the attendants. His mind was not a complete blank, but there was a dim consciousness. These facts point to the case having been one of melancholia attonita, melancholic stupor; not acute primary dementia, better called anergic stupor.

There was a delusion expressed in the explanation of his illness which he gave shortly after his recovery. He thought that he had offended God, and in consequence a great horror came over him, which paralysed his mental faculties and took away his power of speaking, eating, and moving. He says that while in this state he often wished to get up but couldn't; that he felt sorry for himself, and wondered how long it was going to last, and how it would all end, and what would become of his family. He wished that he were able to support them.

It is difficult to know what value to attach to this explanation. That it cannot be dismissed as a pure fabrication is evident, but at the same time there are discrepancies in some of his statements as compared with actual facts. His memory is distorted, and he unconsciously adds a little.

There are other points in favour of this case being one of melancholic stupor; his muscular condition was passively resistive. His habits were cleanly, and there was no difficulty in keeping him clean if he were regularly raised.

As against this diagnosis, however, it must be noted that he always slept well, and his age was much above the average.

It will be observed that he did not begin to improve permanently till about nine or ten months after the second attack of erysipelas, so it could not have been a factor in his recovery.

Pathology.—Dr. Wigglesworth in the *Journal of Mental Science* for October, 1883, published a paper on certain cases of mental stupor, and came to the conclusion that the

pathological basis is a primary inflammatory affection of nerve cells, best marked in the so-called motor cells, and possibly originating in them; but also showing a decided tendency to spread beyond their area. He states that the result of such inflammatory affection involving a multitude of nerve cells and plexuses would be to produce in the mind of the person affected a multitude of vague and incoherent thoughts over which he would have no control, and that he would be absorbed in the contemplation of his thoughts and in proportion to such absorption would be insensible to external stimuli. Now if this were so in the case above detailed, the inflammatory affection must have lasted for nearly six years, at any rate for four or five years, as the symptoms of deep stupor were well marked during all that time. But the patient recovered, and therefore the inflammatory process must have ended in resolution.

It would be difficult to find an analogous case to this in which inflammation lasted for some years in an organ and ended ultimately in resolution; the organ returning to its natural condition and performing its functions as before. We may have inflammation in the kidneys lasting for years, but destruction of the kidney cells is as a rule in proportion to the duration of the inflammation, and there is never recovery nor can there be. Of course it is the interstitial form of nephritis that is the more chronic, but the modern view is that the parenchymatous constitutes a primary stage, in some cases at least, to the interstitial form. At any rate in the kidney, after a chronic inflammation, the cells become disorganised and ultimately disappear, leaving scar tissue in their stead. But if this happens in the kidney why should it not happen in the brain? Why after an affection of some years' duration should the cells of the cortex not become similarly disorganised? If this were so, and if the patient recovered, then the function of the cells so destroyed would have to be performed by other cells which had been unaffected. And, further, at the end of the patient's life, if the brain were examined, there would be microscopic changes marking the former seat of disease. I know of no observations in support of this view.

Discussion.

The patient having been submitted to examination,

Dr. MACPHERSON—I have not seen Dr. Wigglesworth's paper, but, with great deference, I am very much inclined to doubt the possibility of anything like an extensive inflammation of the cells followed by recovery. I have seen microscopical slides from similar cases, in which the cortical cells were perfectly

healthy, and I remember a case of acute mania in which the cortical cells were completely atrophied. I should be extremely doubtful of any possibility of recovery in such a case. I ask Dr. Hotchkis, in connection with Dr. Robertson's remarks on Dr. Edgerley's paper, whether he made a tracing of the pulse in this case. I am sorry to differ from Dr. Robertson's opinion, but it seems to me that the bulk of evidence is on the side of having a high tension in melancholic stupor. Dr. Whitwell has been so patient as to get a continuous tracing of the pulse during the time that the patient was passing from a stuporose condition into a lucid interval, where the pulse is shown to pass from a state of very high tension to a state of rebound. I think that the papers read by Dr. Hotchkis and Dr. Edgerley are of the greatest benefit to us, and beg to thank them heartily.

Dr. HOTCHKIS—With regard to Dr. Macpherson's inquiry, I have to say that there was no pulse tracing taken. His pulse was slow, between 50 and 60, and not very strong; but there was no high tension, in fact nothing at all unusual.

A Case of Diabetic Insanity: Immediate Recovery on Disappearance of Sugar. By KEITH CAMPBELL, M.B., Assistant Medical Officer, Perth District Asylum.

I. C. was admitted into the Perth District Asylum on July 23rd, 1895, under the care of Dr. George M. Robertson.

She was 68 years of age, with the history that for many years she had been eccentric, but that during the week previous to her admission she had given evidence of delusions and a melancholic tendency. She had delusions of suspicion, of persecution, and also of a hypochondriacal nature. She also had hallucinations of hearing.

Family History.—The facts of importance were—(1) that a sister had died insane; (2) that several members of the family had exhibited a strong strain of eccentricity; (3) that there was a distinct tendency to rheumatic gout in the family; (4) that a niece had died of diabetes in girlhood.

Personal History.—At the age of 20 years she had scarlet fever, and subsequently as the result of a chill she had nephritis, and for three months was confined to bed with severe dropsy. Since then she has been crotchety in the extreme, and very eccentric.

I am indebted to Dr. R. W. Irvine, of Pitlochrie, for the information that he had occasion to test her urine at intervals, and found it contained albumen, with a deposit of phosphates. He had not examined it for six years before admission, and he never found sugar.

She has had chronic rheumatoid arthritis for many years, and is to a certain extent crippled by it.

On admission.—Physical Condition.—She was exceedingly stout, and her muscles were in a very flabby condition. As regards voluntary action she was apparently perfectly helpless. She could not stand unless supported, and at once collapsed if the support was withdrawn. In bed, she lay on her back like a log, moving neither hand nor foot. She understood what was said to her, and on one or two occasions she was induced to move her legs a little. She was once also persuaded to walk a few steps. There was no

loss of sensation, although this was somewhat delayed. The knee-jerks were absent; the superficial reflexes normal. No gross nervous lesion could be determined, but she passed urine in bed, and on several occasions her motions. These symptoms were directly traceable to her delusions. On examination the urine was found to be neutral in reaction; sp. gr. 1022, with no albumen. It was not tested for sugar. During this time her appetite was poor and her digestion feeble. Her conjunctiva was injected and icteric, her tongue foul and tremulous, and her bowels inclined to be constipated.

Mental Condition.—She laboured under the following delusions:—That she was dead; that she could not walk; that she could not eat; that her tongue was cut out; that she had no body; that her head was cut off; that she was going to be killed. She had hallucinations of seeing but none of hearing. Under the delusion that she was dead she refused to take her food, and on July 24th she had to be fed with the œsophageal tube, resisting violently. She had to be fed with the tube six times in all, the last occasion being on August 4th. She spoke very little, and then only to insist on her delusions, and no amount of argument could shake her belief in them. For example, if asked to do anything she would say, "I can't, I'm dead;" and if asked how any dead person could speak, she would say that she was quite dead and that her tongue was cut out, only her voice being left.

She was exceedingly quiet, lying as still as death, and judging by her looks she seemed to have no power of voluntary motion. She resisted, however, when the nurse gave her food, or when her position in bed was being changed, but on being left alone she immediately relapsed into a state of apparent helplessness. She continued in this state—absolutely governed by her delusions—for three weeks without any change.

Course of the Case.—On August 16th the nurse in charge reported that she complained greatly of thirst, and in consequence of this her urine was again examined. The sp. gr. was 1030, and there was a marked reduction of Fehling's solution. There had been no increase in the quantity of urine, and the appetite was by no means excessive. She was then put on a strict diabetic dietary, and next day there was a great diminution in the amount of sugar; but she still complained of thirst. The urine for 24 hours measured approximately 3xxxviii., but the difficulty of managing the patient rendered it impossible to ascertain the quantity with exactness.

August 19th.—Patient was sick; conjunctivæ deeply tinged; tongue coated; breath foul. A cholagogue purge was given. The special diet was continued. The urine still contained sugar.

August 21st.—*There was not a trace of sugar in the urine, and in mind the patient was a different woman.* She no longer lay in

bed motionless and sullen, but became bright, cheerful, and ready to engage in conversation. She took her food well, was perfectly tidy in her habits, and wished to get up. She admitted that her fancies about being dead were wrong. She said that she really thought she was dead, and that her tongue was cut out, but that it was "nonsense."

For the next month she was kept on a strict diabetic dietary, and her urine was examined at intervals without any evidence of sugar or albumen being found. The daily amount was never excessive.

During this time also she gained in weight, from 11st. on 1st Aug. to 12st. 11lb. on 4th Sept.

She remained quite well in mind and able to be up daily; free from all delusions, as above noted.

The dietary was gradually relaxed, the urine at the same time being periodically examined, and eventually she was put on ordinary diet.

October 16th.—Patient had a slight relapse. She did not sleep well for a night or two, was rather excited, exalted in her ideas and irritable. She had some vague ideas of persecution. No sugar was found in the urine.

October 21st.—Patient quiet and cheerful again. She continued so till December 2nd.

December 9th.—For a week previous to this date the nurse had noticed that she was depressed, irritable, and drowsy. The mental state did not amount to technical insanity. She was simply unreasonable, crotchety, and full of objections. The urine was examined, and the sp. gr. was 1024—amount not excessive, about seven grains of sugar to the ounce. She was put on a diabetic dietary.

December 11th.—She was much quieter, and less irritable. No sugar.

December 25th.—She had a full dietary to-day, and as a result there was sugar in the evening urine. Next day the special dietary was resumed, and she again recovered mentally, while the urine remained free from sugar.

She is now, on March 18th, perfectly recovered.

Notes on the Case.—The diabetes of this case is probably hepatogenous in origin, and the appearance of the woman—elderly, stout, with distinct symptoms of rheumatic gout, subject to biliary disturbance, with a florid complexion and moist skin, favours this view. The fact that the exclusion of sugar-forming substances from the food stops the excretion of sugar, and that the sugar is increased by neglect of such precautions, are also confirmatory. As regards mental symptoms, the outstanding facts are:—Their marked melan-

cholic nature, the fixedness and overmastering strength of the delusions, and the fact that they were mainly hypochondriacal.

As in other cases reported there was also an extreme and sullen obstinacy, and a stubborn refusal of food.

The notable feature, however, is the synchronous disappearance of melancholic symptoms, and of sugar from the urine. The mental recovery when the sugar disappeared was so sudden and so complete that it was evidently more than a coincidence; and another fact that strengthened this view of a relationship between the phenomena was a change in the patient's mental state for some days before sugar was again found in the urine (Dec. 9th).

Her delusions had not returned, but she was depressed, irritable, crotchety, and abusive. These symptoms have been observed in many cases of diabetes, and have been described as one of the abnormal mental states not amounting to actual insanity which appear in diabetes (*Journ. Ment. Science*, Vol. xlii., p. 20). On the sugar-forming constituents of the food being removed the sugar disappeared from the urine, the irritability passed off, and the patient again resumed her cheerful state of mind.

There seems undoubtedly to have been a very close connection between the diabetes and the mental symptoms, and from the changes in these symptoms following on changes in diet it would seem as if the diabetes stood to the insanity in the relationship of cause to effect. The remarkable similarity in the character of the main symptoms in this and other recorded cases of insanity in which sugar has been detected in the urine of the patient (Clouston, *Mental Diseases*, p. 600) is a noteworthy fact from a clinical point of view, and confirms the belief in a distinct type of diabetic insanity, of a melancholic variety, with delusions of a hypochondriacal nature, and ideas of suspicion and persecution.

These delusions are possibly due to misinterpretation of the lethargic and wearied sensations actually experienced in diabetes mellitus.

Note on a Case of General Paralysis with Marked Sensory Symptoms. By WILLIAM C. SULLIVAN, M.B., Stewart Scholar in Mental Disease, R.U.I., late Clinical Assistant, Richmond Asylum, Dublin.

P. T., aged 36 years, army pensioner. History of syphilis, contracted ten years ago, while serving in India; also of sexual excess. Married, has two children, both healthy. Symptoms date back two years, when patient began to suffer from convulsions, treated as idiopathic epilepsy. Admitted to the Richmond Asylum in February, 1892.

He then presented some degree of tongue tremor, slight flattening of face, articulatory blurring, and very exaggerated patellar reflex; pupillary reactions and fundus oculi were normal, no disorders of common or special sensibility. Mentally there was a state of mild exaltation, not crystallised in any delusion.

Patient had no mental or physical change from date of admission to April, 1892, when he had a number of attacks of *petit mal*, preceded on each occasion by darting pains in the lower extremities, and followed by a temporary accentuation of the physical signs. With the onset of these "cramps," as the patient termed them, his optimism disappeared, and he exhibited a tendency to persecutory ideas, attributing his sufferings to drugs in his food, etc. When the attack passed off, the exaltation returned and was more marked, patient declaring that God had come to him, touched him and cured him. In May a more severe congestive attack was succeeded by temporary aphasia and right brachial paresis, while the mental state was very depressed.

A remission of mental and physical symptoms followed this, lasting until September, when another similar attack occurred. In none of these attacks could any sensory disturbances be detected except the darting pains before the onset.

Towards the end of November patient had a very severe congestive seizure, preceded by intense darting pains, and leaving a condition of left hemi-paresis. With this was associated a mental state of panic terror; with his sound hand patient grasped his paretic arm, shook it, gazed at it with an expression of horror and fear, shrieking, "Take it away, take it away; the big serpent is biting me!" Furor was too intense to allow observation of sensory condition. This excitement subsided after some hours, and paretic symptoms passed off, leaving patient very dull and confused; he stated that a big serpent had been placed upon him, and had bitten him in the left side, but that God had saved him because of his holiness. Sensibility to pain and touch could now be made out as distinctly lessened on the left side.

No further symptoms appeared until December 9th, when there was a revival of the furor with the former delusion, but without

motor paralysis. On December 25th another congestive attack was followed by left hemiplegia and hemianæsthesia; patient was happy, fondled his paralysed and anæsthetic arm, speaking of it as his "little son, the fine little child that God had brought to him."

In a day or two, localised motor and sensory paralysis passed off, but dementia became profound. Patient died of cardiac paralysis on January 9th, 1893.

Remarks.—It will be observed that throughout this case sensory symptoms were more prominent than they usually are in parietic dementia; and further that the influence of these abnormal sensory conditions on the patient's emotional state and on the contents of his delusions was particularly clear. Each change from exaltation to depression, from delirious conceptions of a gay to those of a sad character, appeared to coincide with and be caused by the occurrence of painful sensations referred to the periphery; and the cessation of these sensations or their replacement by sensations of a pleasurable tone was constantly accompanied by a return of the sense of *bien-être* with grandiose delusions.

I have thought this case worth recording as illustrating so clearly the important rôle which the condition of sensibility plays in general paralysis in determining the character of the transient psychic symptoms which colour the dementia in this disease.

OCCASIONAL NOTES OF THE QUARTER.

The New Journal.

The rumour that a new contemporary is to appear in connection with the Association of Asylum Workers is not as yet confirmed; indeed, we are informed that the matter is still in abeyance.

The above-named Society now numbers so many members, and is so largely supported by our own associates, that whenever the new birth may occur we may be assured that it will aim, not only at the advancement of the interests of asylum workers, but also at the development of asylum work.

In this assurance we shall give a hearty welcome to the new journal whenever it may appear.

Non-Specialist Asylum Appointments.

The discussion on this subject by the South-Western Divisional Meeting, and the resolution passed, prove that the specialty is alive to the evils that may arise from the appointing of inexperienced medical men to the control of asylums. The danger of such appointments being made does not arise only from the ignorance, personal interests, or parsimony of local authorities, but may come from other branches of our own profession. In "Notes and News," under the heading of "Insanity Law," we quote a recommendation by the *Medical Record* (U.S.A.) that the medical representative on the Lunacy Commission for New York State should be a "neurologist" !

The immediate result of such appointments will be, that the highly qualified medical men who are now filling junior posts will retire from the specialty, and the advance in scientific study and treatment of the insane will be retarded.

The Commissioners in Lunacy must appreciate the importance of such a state of things, and would probably welcome and assist a representation of the evil and injustice involved to the Home Secretary and the Lord Chancellor.

Local authorities will always be liable to be influenced as already suggested, unless they are definitely controlled by superior authority. Appeal to their judgment ensures no permanent conviction. Committees are said to have no conscience, and when triennially elected they certainly have short memory.

Colonial Branches.

The very important and interesting question of the establishment of Colonial branches of this Association will probably come before its members for decision at an early date.

The suggestion arises from the already established nursing examination at the Cape, and from an application for the extension of this to New Zealand.

The enlargement of our work in this manner renders it desirable that some representative of the Association should be appointed in each Colony; and it is probable that the nomination of such a representative would best be arrived at with the assistance of the members of the Association in

each Colony. To do this would practically necessitate the establishment of branches.

Colonial branches, if thus instituted, would not probably often result in meetings, owing to the long distances that separate the members. They might, however, develop a system of criticism of papers sent by post, or in other ways keep up an active interest in their own work and in that of the Association.

*National Society for the Employment of Epileptics.**

This Society does not appear to receive the charitable support that it needs and deserves. In a recent appeal for assistance it was pointed out how greatly England was lagging behind other countries in this respect. In Germany, for instance, there are no less than a dozen epileptic colonies, of which Bielefeld, the chief, has an income of thirty thousand pounds, chiefly derived from charity.

In America several colonies already exist, while in Pennsylvania and New York State new colonies are being formed on a most liberal basis. In the first-named instance the State provides the land and one donor gives 50,000 dollars.

In the whole range of preventive medicine there is probably no better object for charitable effort than this. Epileptics constitute eight per cent. of the admissions to our asylums, and there can be little doubt that this number would be reduced by a considerable extension of the colony system; epileptics in our dense population being at a greater disadvantage than in the countries quoted, and needing help more.

The applications for admittance to the existing colony are greatly in excess of its resources, and it is suggested that several others should be established under local management in various parts of the country.

We trust our readers will therefore not neglect to use the knowledge, influence and opportunities which they possess to advance the establishment and development of such colonies in our own country.

* The central address of the Society is at 12, Buckingham Street, Strand.

The Austrian Curatel Procedure.

In Austria the Curatel law has long applied, not only to the insane, but also to habitual drunkards and others deficient in self-control. This law provides for the appointment of a Curator, under whose control the patient is put when discharged from an asylum, etc. The Curatee can apply from time to time to the Court for the annulling of the Curatel, and the decision rests on the evidence of State physicians and other testimony. In some instances repeated applications have been made before the discharge from Curatorship has been granted.

One result is, as pointed out by Professor Schlangenhäusen,* that in Lower Austria there is great over-crowding in the asylums from the admission of forty per cent. of habitual drunkards. These, as elsewhere, are found to exert a deleterious effect on the ordinary insane, and the Austrian Government therefore proposes to construct for drunkards special asylums to be under State control.

The appointment of Curators in certain cases of insanity, as well as in states of loss of self-control, would certainly constitute a valuable supplement, not only to the treatment of these conditions, but also in safeguarding the community from those who are dangerous.

A provision of this kind might certainly be made with advantage in the forthcoming legislation by Parliament in regard to habitual drunkards, as it probably will be in the similar legislation for compulsory curative procedure which is under the consideration of the Reichsrath. Such an addition to legal control might be made without the sweeping re-modelling of our lunacy system which some of our lunacy reformers would advocate.

Attempted Attendants' Trades Union.

The attempt to form a trades union of attendants in Ireland has been quashed with the firmness and promptitude that the occasion demanded. A trades union is as impossible in an asylum as in the army or navy. Discipline would be impossible, and no confidence could be placed on a staff which would at any moment be paralysed by the action of an irre-

* *Wiener Medicinische Press*, Fl. 9, 1896.

sponsible, and often tyrannously autocratic trades union committee. The Report of the last meeting of the Irish Division in "Notes and News" forms a permanent record (if any were needed) of the right method of dealing with such attempts at insubordination.

Pensions and Gratuities.

The present time would seem to be most opportune to press the claims of those engaged in the treatment of the insane for assured pensions and for gratuities under special or exceptional circumstances.

The discussion of the pension question some years back revealed very opposing views among Asylum Medical Superintendents. The last few years, however, have brought a considerable amount of experience on this question, and it would be desirable again to discuss it, since there is a possibility that greater unanimity may now be found to prevail.

The gratuities question is one on which there has been an unanimous expression of opinion, and there is probably a good opportunity of making the granting of these legal in the Lunacy Amendment Bill of the present Session if the members of this Association individually and collectively bring their influence into play in the proper quarters.

The grievous injury of a gardener attendant at the West Green Asylum recently reported is at once an illustration of the dangers of the occupation and of the necessity for power to grant gratuities or allowances to the widows and children of those who lose their lives in the performance of their duty.

Increase of Lunacy.

The increase of lunacy has again been made the subject of question in the House of Commons by a Member who has interested himself on the point, and has expressed very strong opinions thereon. He proposes an International Commission on the subject. Such a Commission might collect interesting and valuable information, but we doubt if it would bring us any nearer a definite conclusion from existing statistics than has been reached by the Commissioners for the three divisions of the country in their more recent reports.

Crime and Insanity.

The Report of the Departmental Committee on Prisons, the chief recommendations of which—so far as they affect the subject of insanity in prisons—we reproduce under the heading “Notes and News,” contains much of interest to alienists, by whom it will be welcomed as evidence of reform and progress. The Report opens up a prospect of co-operation between asylum and prison workers, which cannot but make for a better understanding of the sources and relationships of crime and insanity, and promote our efforts to lessen the sum of unhappiness caused by the heedless propagation of these great degenerations. Too long, indeed, have the alienist and the criminologist worked apart, and a distinction, we venture to assert, quite unnatural has been drawn between their spheres of labour. We should be curious to learn how many instances could be adduced of co-operation between asylum and gaol medical officers, in those localities in which the asylum and the prison are contiguous; to what extent the medical officers of the one institution have taken advantage of the opportunities which offered to familiarise themselves with the cases to be found in the other. There may possibly be justice in the reproach that both our prison colleagues and ourselves have been remiss in not bringing before the notice of the proper authorities, with adequate persistence and force, the need for taking a common basis of study, and for associated labour. The desirability of keeping distinct institutions for dealing with insanity and crime might even be questioned by some. Wholly separate institutions for the study of the different abnormal and degenerative states of any given bodily organ, other than the brain, would assuredly be considered as unnecessary.

Turning to the recommendations of the Report, we early note one which strikes us as eminently desirable, namely, “That candidates for medical appointments in prisons should be required to show that they have given special attention to lunacy.” As is truly observed, “The detection of disease in its earliest stages taxes the skill of the practitioner to its fullest extent, and in mental diseases this is especially the case. Here medical men of great skill and experience, but without any special training in this department of their art, are undoubtedly at a disadvantage.” The Report goes on to allude to the Belgian system, by which experts are retained for the detection of insanity in criminals; and suggests that some step of the kind might be taken, with a view of

inspecting convicts during their period of isolation. We are certainly of opinion that if the recommendations on this point are carried out much will have been done to prevent the punishment of the irresponsible. In Appendix III. of the Minutes of Evidence we find a Table, supplied by the Medical Inspector of Local Prisons, showing that, in the year ending March, 1889, the number of sentenced prisoners found insane upon reception amounted to 93; and he proceeds to observe that "it is evident from these figures that insane and irresponsible persons have been dealt with as sane and responsible; that is to say, they have been sent to prison under sentence." Although in London the committal of insane persons to prison is largely prevented by using Holloway Prison as a place in which accused persons of doubtful sanity can be observed and tested, it can scarcely be doubted that in the provinces instances of such committal are occurring not infrequently. Even in Holloway the facilities for giving thorough attention to individual cases, whereby alone just conclusions as to the mental state can be formed, would appear to be inadequate, since we find the Report (based in this respect, as in all others, upon the evidence of expert witnesses) advocating that "the medical staff in Holloway and other prisons similarly circumstanced should be strengthened."

Whilst referring to the subject of the early detection of insanity in prisoners, we offer the suggestion that it would be advantageous to consider the propriety of reforming the process by which the Treasury is informed concerning the mental condition of a prisoner. At present (we refer to the usual procedure) a report is furnished by the Superintendent of the local asylum. We think that the results would be more uniformly satisfactory if in all cases such prisoners were examined in addition by a consultant-expert, preferably one retained by the Treasury for that purpose. If, finally, we could be spared the primitive course by which a local practitioner is permitted to present his opinion in court, upon behalf of the defence, in respect of a questionable case of insanity, in opposition to that of the Superintendent of the Asylum—a procedure by no means instructive or dignified—an appreciable saving would be effected in the time of the court, and the way cleared for the introduction of more advanced methods.

Another recommendation to which we would refer is that the various members of the prison staff should go "through a course of systematic and scientific instruction. Lectures

should be given by experts in criminal anthropology," etc. We have no sympathy with those connected with asylums and prisons in this country who deride the work of Lombroso and his pupils. Even though we are unable to agree with much that is taught by this school, we accept such investigations as being in the proper spirit, and should deem it evidence of progress if the same lines of inquiry were systematically followed in this country. Prison officials, like their asylum *confrères*, are in danger of losing the light of research amidst the murky details of administrative duties. We are glad to note the Report recommending that prison officials should be instructed in their work "over and above the formal discharge of routine duties."

Other recommendations refer to the treatment of the weak-minded class, of habitual criminals, and habitual drunkards. Separate treatment is recommended for all these. With reference to the first-named, we find the somewhat naïve remark, that it is "a question whether the epileptic and obviously weak-minded class should be sent to prison at all." We hasten, however, to add that the humane and enlightened tone of the Report leaves no room for doubt as to the manner in which, in the opinion of the committee, this question should be solved. In the case of habitual drunkards, the recommendation of the Committee on Inebriates, that magistrates should have power to commit for lengthened periods, is confirmed.

The Report closes with a memorandum on Insanity in Prisons by Dr. J. H. Bridges, a member of the committee. He has no difficulty in rebutting the sensational statements made by a writer in the *Fortnightly Review* for April, 1894, and by others, to the effect that the existing prison system promotes insanity.* In the vast majority of cases of insanity recorded in local prisons during a given year the disorder was noted on admission or within one month of admission; and the probability is that careful inquiry, with due knowledge of the history, would have shown the existence of the seeds of the disease in several of the few cases remaining. The fact that the insanity is thus early detected, pointing clearly, as it does, to the existence of the malady prior to imprisonment in a large number of the cases, is an obvious argument for the early examination of accused persons by specially trained physicians, with a view to determining the question of responsibility prior to committal to gaol.

* See also Dr. Baker's article on "Insanity in English Local Prisons," *Journal of Mental Science*, April, 1896.

PART II.—REVIEWS.

The Forty-fourth Report of the Inspectors of Lunatics on the District Criminal and Private Lunatic Asylums in Ireland.
1895. Thom and Co., Dublin. Octavo; pp. 198.

The Inspectors' Blue Book for the year 1894 begins with the usual summary of the number and distribution of the insane in establishments:

	On 1st January, 1894.			On 1st January, 1895.		
	Males.	Fe- males.	Total.	Males.	Fe- males.	Total.
In District Asylums	6,818	5,616	12,434	7,002	5,769	12,771
„ Central Asylum, Dundrum	130	26	156	140	21	161
„ Private Asylums	281	361	642	293	353	646
„ Workhouses	1,718	2,326	4,044	1,686	2,390	4,076
„ Prisons	—	—	—	—	1	1
	8,947	8,329	17,276	9,121	8,534	17,655

The Inspectors are again careful to point out that the insane in establishments do not include the insane in private dwellings or wandering at large.

“This summary shows an increase of the insane under care in all the different institutions receiving lunatics, viz., an increase of 337 in District Asylums, of 5 in the Criminal Asylum, of 4 in Private Licensed Houses, and of 32 in Workhouses.

“Unfortunately the falling off which occurred last year in the growing increase of the registered insane has not been maintained, the increase at the end of the past year being above that of the year before (which was only 152), and above the average increase for the past ten years, which was 330.

“Table I. shows the number and distribution of the insane under care in Ireland on the 31st December of each year from 1880 to 1894. In that time the numbers have increased from 12,982 to 17,655, an increase of 4,673.”

During the interval in question the population of the country as estimated in the middle of each year had sunk from 5,202,648 in 1880 to 4,600,599 in 1894.

The Inspectors have thought it necessary to quote at full length the Conclusions which they presented in their last previous Blue Book, as the result of their inquiry into the increased number of the insane registered in Ireland. They seem to maintain that the increase is mainly apparent, but partly real. Their present views are not identical with those which they expressed at an earlier date (a fact which Mr. Corbett, M.P., has recently touched on with some severity in the *Fortnightly Review*), and are opposed to the general trend of well-informed opinion on this point. We are therefore hardly inclined to accept their arguments as conclusive. They state that the main factors which contribute to the development of occurring insanity in this country may be classed as:—

- (a.) *Heredity.*
- (b.) *Consanguineous marriages* among those having any tendency to nervous disease.
- (c.) *The innutritious dietary* of the poorer population tending to produce anæmia and constitutional weakness, which favour the development of scrofulous and neurotic disease.
- (d.) *The immoderate use of certain nervous stimulants.*
- (e.) *The acute agricultural depression and dislocation* so widely experienced in recent years.

Now we do not see that any of these causes, except perhaps the last, has any real bearing on the question at issue. If heredity were a direct cause of the *increase* of insanity it must be one which in itself is increasing at such an appalling rate of progression as would threaten the early extinction of humanity (at least of sane humanity) altogether. The statistics of the western islands, notably Tory, go to disprove the efficacy in the production of insanity of consanguineous marriages, which are probably rarer in Ireland than in any other country. The dietary of the Irish peasants has vastly improved since the old days when the staple food of the country was the potato. With regard to alcohol, the only nervous stimulant the abuse of which is an undisputed cause of insanity, the habits of the people have improved and are improving. Of the Ireland of olden times it was said, "In Ireland no man visits where he cannot drink." Happily that is certainly not now true.

With reference to the very interesting question of agricultural depression the information collected is too vague to enable any very definite conclusion to be arrived at.

The following table is given, than which, say the Inspectors, "nothing, in our opinion, would point more forcibly to the effects of accumulation."

PROPORTIONAL AGE DISTRIBUTION of the total Insane at the Census Periods, 1871, 1881, and 1891.

—	1871.	1881.	1891.
All ages	1,000	1,000	1,000
0-15 years	72	52	36
15-25 years	158	134	118
25-45 years	448	450	426
45- 5 years	258	285	334
65 years and upwards	64	79	86

District Asylums.

The admissions to District Asylums numbered 3,229: being 2,448 new admissions and 781 readmissions. One thousand three hundred and nine patients were discharged recovered, 465 not recovered. The proportion of recoveries to admissions was 40·5 per cent. The deaths numbered 1,108, being in a proportion of 8·8 per cent. on the daily average number resident. "In 287 of these cases post-mortem examinations were held. This is a considerable increase on past years, and as the medical staff in these institutions is strengthened, we feel confident that such examinations, so necessary for the safety of the insane, and so important for the furtherance of scientific knowledge, will every year become more frequent."

It is very much to be regretted, in the interests of the insane as well as in the interests of medicine, that the Inspectors were not able to press upon the Privy Council the necessity for providing in the new rules for the performance of autopsies as portion of the duty of the medical staff. On the contrary in the new rules post-mortem examinations are only referred to in connection with burials, and are associated with anatomical examinations, apparently with the design of rendering autopsies odious, and even of penalising the performance of them unless in the case of unclaimed bodies. It is, perhaps, scarcely to be wondered at that in the majority of the District Asylums post-mortem examinations appear to

have been few, while in no less than nine none were performed during the year.

Five suicides are recorded. Two patients cut their throats with dinner knives. One strangled herself with a roller towel; one precipitated herself from a window; another hung himself from a ventilator in a single room. One patient died from impaction of food in the gullet. A patient at the Richmond Asylum, Dublin, died from violence, having sustained "during the night" a fracture of the sternum and several ribs, with rupture of the liver. An attendant, who was alleged to have inflicted the injuries, was prosecuted on a capital charge, but the jury disagreed.

Accommodation.

It would appear that the crying evil of overcrowding has at last led to some serious steps being taken in the various public asylums. "Under existing legislation on the subject the duty of providing adequate and suitable accommodation for the treatment of the insane poor is exclusively vested in the Board of Control. . . . As a result of the Board's exertions, extensive additions have been made, or are in progress, or in immediate contemplation in connection with every District Asylum with the single exception of Ennis." "Immediate contemplation" unfortunately in Ireland seems not to be a very rapid process. The expense of extensive buildings for the insane is heavy in a poor country, and, although the Inspectors courteously compliment the local authorities on their cordial co-operation, we fear from the statements of Asylum Governors, which appear from time to time in the local papers, that the central authority somehow fails to always commend its views or its methods to local opinion. At Armagh, Ballinasloe, Carlow, Clonmel, Cork, Downpatrick, Enniscorthy, Killarney, Kilkenny, Letterkenny, Limerick, Maryborough, Monaghan, Mullingar, Sligo, and Waterford additional accommodation is being provided, and the older buildings appear to be undergoing a complete remodelling. The plans at Armagh, Ballinasloe, and Downpatrick appear to include special hospital accommodation. We hope "immediate contemplation" may be given to the necessity for making suitable hospital accommodation everywhere. If there is one thing more than another which modern medical experience shows, it is that provision which is good enough for healthy chronic cases may be wholly unsuited for the sick and for acute cases. Until this is

thoroughly understood and acted upon the medical treatment of the insane will be backward and defective.

The new asylum for the County of Antrim has been begun. The second asylum for the Dublin District at Portrane has apparently got as far as the embryo stage; plans have been prepared; tenders are expected.

At Belfast City, "the Purdysburn estate, some few miles outside the city, has been purchased as the site for the new District Asylum. It contains about 300 acres, and it is proposed to at once convert the manor house already existing on the site into accommodation for 76 chronic working patients who will be employed on the farm, thus relieving the overcrowding in the existing asylum."

At Londonderry, "The decision of the Governors to abandon the present site of the Londonderry Asylum has met with the full approval of the Board of Control, and during the past year a site has been selected, called Gransha, at some little distance from the city on the other side of the river. At present negotiations are in progress with a view of obtaining a water supply from the Corporation of Londonderry City, and if these can be satisfactorily concluded, it is to be hoped no further cause of delay in obtaining tenders for the erection of the buildings will be experienced."

It is difficult to judge from the report before us what is being done at the Richmond Asylum.

We are told that "during the year various temporary buildings have been erected at the Richmond District Asylum, so as to provide sufficient space for the accommodation of all the patients resident in the institution. This work was carried out by building blocks, the walls of which consist of two layers of pitch pine with felt between. The roofs are constructed of corrugated iron over a layer of felt. A kitchen, scullery, and stores were also erected at the main building."

The improvements indicated in the last sentence must certainly have been acceptable, but it would be interesting to know how the main building got on heretofore without a kitchen.

The present report is a little scanty in detail, but in the forty-second Report of the Inspectors it is said of the Richmond Asylum—"The number of patients now almost reaches 1,500, whereas the asylum only accommodates about 1,100." Is it meant, then, that the new provision which satisfies the

Inspectors as rendering the asylum sufficient for all the patients resident in the institution is adequate for 400 patients? If so, it is surely much to be regretted that more detail has not been given with reference to this enormous provision of "temporary accommodation," as large as the total of most Borough Asylums when first erected.*

Insanitary Conditions.

Epidemics of fever from year to year at Castlebar Asylum are supposed to be due to polluted water. At Enniscorthy a defective water supply is also a source of inconvenience and danger. At Maryborough the same condition, combined with bad drainage, is credited with the production of epidemics of dysentery and typhoid fever. An epidemic of typhus fever at Killarney, which affected five patients, killing one, was traced to an external source. Erysipelas was introduced by a patient into Mullingar Asylum, and affected twelve of the inmates, killing four. At the same asylum a case of enteric fever occurred. "This fever was caused by an escape of sewage from a defective soil pipe." It is well to be definite sometimes, but will leakage from a defective soil pipe alone cause typhoid fever? "The sanitary condition of the Richmond Asylum has continued to be a source of anxiety to all connected with its management. Outbreaks of dysentery and diarrhoea have been prevalent, and in the autumn some cases of small-pox occurred." It is not mentioned how the small-pox was introduced. The singular epidemic of *bèri-bèri* which visited that institution is thus described:—

In the early summer an epidemic broke out, resembling in its symptoms an Eastern disease known as *bèri-bèri* or "the bad sickness of Ceylon." The disease appeared both in its acute and chronic aspects, and its occurrence, which had never before been

* With regard to former schemes for improving that asylum, see *Journal of Mental Science*, Vol. xli., p. 330. On May the 16th, 1895, less than two months before the date of the report before us, this matter was again brought before the House of Lords by Lord Belmore and Lord Ashbourne, who was then in opposition. There seemed to be a dispute as to whether the expenditure contemplated at the Richmond Asylum was to be £60,000 or £110,000, but Lord Ribblesdale admitted that he himself and the Government of the day for whom he answered (it was during Mr Morley's Chief Secretaryship) were favourable to the scheme of relinquishing the old buildings, but he said that the Board of Control could not see their way to adopting this plan. It is not easy to see why the Inspectors have not referred to this question. Clearly, the "temporary accommodation" which has proved so satisfactory must have cost much less than the smaller of the sums mentioned in the gilded chamber.

reported in its epidemic form in the British Isles, attracted much public attention and gave rise to a good deal of discussion as to its origin. The overcrowded condition of the wards in both male and female houses operated no doubt as a marked predisposing cause, and led to the multiplication of the specific germs which must have been in some way imported from abroad. The total number of occurring cases was 152; the deaths, 25; the first case was recognised early in May, and the last case reported in November, since which time the institution has been entirely free from the disease. The epidemic during its whole course attacked only the insane inmates of the institution; neither officials, attendants, nor their families, nor visitors having in any way suffered from it. Amongst the inmates, patients admitted to the asylum a few months before were found to be as liable to the disease as those who had been years within its walls. Neither sex nor age appear to have had any prophylactic power, both young and old being attacked without distinction. To meet the overcrowding it was decided to erect temporary accommodation for the superfluous population, pending the erection of the new asylum at Portrane.

It is unfortunate that no steps were taken earlier to meet the overcrowding, so long recognised and so loudly complained of. No further medical details are given: no suggestion is thrown out of a possible source of origin. Neither is the connection so frequently observed in the East between endemic dysentery and *bèri-bèri* dealt with. The Inspectors do not say anything of the occurrence of a similar visitation in institutions for the insane in other countries. They speak of *bèri-bèri*, by the way, as an Eastern disease. That is hardly quite correctly said of a disease so prevalent in South America, and which has occurred in epidemic form in several places in North America, for instance, in Newfoundland.

Cost of Maintenance.

The average net cost of maintenance in District Asylums during the year was £22 2s. 6d., or 8s. 6d. per head per week. The maximum rate was at the Richmond Asylum, £27 0s. 11d., and the minimum at Castlebar, £17 2s. 9d. The disparity is very remarkable.

Memoranda of Inspection.

Appendix F. contains the memoranda made after inspectorial visits to the various asylums. They tell a wonderful story of overcrowding and structural difficulties everywhere, and suggest that the amount of responsibility and work

thrown, not only upon the medical officers, but upon the Inspectors, if the asylums are ever to be brought up to the modern standard, is vast. We notice gladly that the latter steadily support an increase in the strength of the medical staffs; that more attention is being given to nursing; that trained nurses are being recommended for employment in many places, and have been employed in several; that a full proportion of attendants to patients, both by day and night, is persistently pressed; that the special training of attendants, undertaken under the regulations of our Association, is urged and commended, and that generally an endeavour is made to raise the standard of asylum work and asylum workers, both medical and lay—a specially difficult task in a country where office is popularly looked upon as a mere milch cow, and where intrigue and not work is generally esteemed the road to success. These memoranda contain several appreciative and kindly notices of individual medical officers, both superintendents and assistants, particularly at the asylums of Armagh, Mullingar, Ballinasloe, Londonderry, and Downpatrick.

Criminal Asylum.

A special appendix is given to the statistics of the Central Asylum, Dundrum, the memorandum of inspection there, and the report of the resident physician. The Inspectors note—

With regard to employment, the system of payment for work done, which has now received the sanction of the Treasury, would appear to have produced most satisfactory results. The inmates, many of whom would otherwise wander about in idleness, seeking some mischief to do, dangerous to themselves and others, are by this means induced to assist in useful work, and their lives are made happier and feelings of self-respect and control are inculcated.

The Insane in Workhouses.

The Inspectors continue to deplore the increased number of the insane in workhouses. The very careful memoranda of inspection of certain workhouses show that the state of affairs recently made public in the *British Medical Journal* is not exaggerated.

Little that is new is said about the private asylums.

The Inspectors again draw attention to two great wants in provision for the insane in Ireland: the lack of accommodation for middle-class patients and the absence of a national

institution for the training and education of idiot and imbecile children.

On the whole we leave the Inspectors' Report with some feeling of regret for the difficulties under which those gentlemen evidently labour. To endeavour to improve asylums in a land where there appears to be little educated public opinion favourable to advance in the treatment of the insane is in itself an irksome task, and the position of the Irish law in this matter makes further difficulties. The constant intervention of the Privy Council must hamper the action of the Inspectors very materially. The management of great medical charities through a Government bureau presents grave inconveniences, and the country where this is needful cannot be favourably situated for progress. Consequently we find that the Privy Council regulations are not always as apt as we should wish, and that though they throw grave responsibilities upon the Inspectors and upon the Medical Superintendents of asylums, they do not give proportionate powers to either. In Ireland, too, the rule of Government departments is not popular, and much of this unpopularity must cling to the Inspectors and tend to render them less useful than if their hands were more free. Similarly, with reference to the Board of Control. The Inspectors are *ex-officio* members of that body, whose position with regard to provision for the insane they have correctly laid down in words quoted above. The notion of a central board vested with the responsibility of building and amending all the asylums in the country is a hard one to comprehend according to English ideas. It is clear enough that, with the other work which is thrown upon them, the Inspectors cannot have time to undertake this enormous task. But they are not in the independent position of critics, since they themselves are members of this ruling body. It is as if the Superintendent of an asylum were a member of the Committee and compelled to acquiesce in every vote which a majority carried. This situation would be well-nigh intolerable, and would call for the exercise of almost superhuman sagacity, tact, and courage. The Board of Control, also, unlike other great spending departments, publishes no report of its transactions. Indeed, it is doubtful to whom it could address such a report, or to whom it is responsible. One of the least inconveniences resulting from this fact is that the history of important proceedings may need to be searched for partly in the Inspectors' Report

and partly in Hansard, and not found in a wholly intelligible form in either. But, if the Board of Control are beyond criticism, the Inspectors are not, and the innumerable points at which they are brought into contact with the Governors of Asylums give the latter abundant opportunities of avenging upon them the delays and indecisions of the unpopular Board of which they are only two members. And so, instead of gaining the influence they require, they lose prestige, as well as independence, by their connection with the Board of Control.

Les Causes de la Folie, Prophylaxie et Assistance. Par EDOUARD TOULOUSE. Paris: Société d'Éditions Scientifiques, 1896, pp. 480. Price 7fr. 50.

In this work, largely one of compilation, Dr. Toulouse has endeavoured to bring forward facts bearing upon the etiology of insanity, and made an attempt to systematise them with the view of placing the subject upon a more secure basis. While etiology is obscure in diseases generally, nothing is more true than that it is most obscure when we deal with mental diseases, and no one can read this treatise without realising how extremely complex the question is. To facilitate descriptions, Dr. Toulouse considers separately the questions of predisposition and direct causes, the latter being subdivided into social, biological, physiological, moral, physical and pathological causes, but, beyond that this arrangement is convenient, he attaches no importance to his classification, while he urges the rejection of all classifications for the present which are rather based upon theoretical than clinical data.

Insanity is considered by the author in its widest sense—that is as a congenital or acquired disturbance, short or prolonged, of the intellectual, emotional, and voluntary faculties.

Book I. deals with predisposition (hereditary, congenital, or acquired), and, while Dr. Toulouse attributes the utmost importance to it in the evolution of insanity, he is unsparing in his criticism of those who seek to minimise the effect of so-called “occasional causes.” The general question of heredity is here considered. Direct heredity is rare in mental diseases, and its apparent effects may often be explained by imitation or contagion. In discussing the

question of "dissimilar heredity" a very useful summary of the relations of general paralysis to alcoholism and nervous diseases in the progenitors is given. Before we are able to estimate the importance of the association of various diatheses with insanity, as is well insisted upon by the author, it is necessary that we should know the exact proportion in which they are found in healthy families on the one hand, and in insane families on the other, but both factors of the problem, and especially the first, are practically unknown.

In the chapter on social causes, in examining the influence of civilisation on insanity, the conclusion is that there is very probably an increase in insanity, although one cannot base this conjecture on the large number of inmates which one finds in asylums, arising from the prevalence of alcoholism and from the fact that fewer idiots, cretins, epileptics, and demented are kept at home than formerly.

In the chapter on physiological causes we find a good *résumé* of the relations of menstrual evolution and its disturbances to insanity. The etiological relation between general paralysis and sexual abuse the author considers is obscure, and he doubts that sexual excess is an all-important factor in the production of insanity.

A careful analysis of its factors shows how complex is in reality what is called "puerperal insanity," but at the same time Dr. Toulouse points out that during pregnancy, labour, the puerperal period, and lactation respectively, some dominant factor is at play such as auto-intoxication, shock, infection, etc. Still, it is necessary that each case should be inquired into, and we should not rest content with labelling insanity occurring at or about labour as puerperal.

While we may still consider certain causes as moral causes related to insanity, we must remember that there is in reality no relation between the kind of emotion and the form of mental disease. Dr. Toulouse has also much of interest to say on the question of mental contagion.

The chapter on physical causes (in which, among other subjects, there is a good analysis of the relations between general paralysis and traumatism) is especially instructive, and serves to illustrate by excellent examples two ideas, the demonstration of which is attempted in the book:—the first that, mental disturbances being dependent upon one or several morbid processes occurring in a disease, it is evident that all classifications based upon large nosological divisions

are erroneous, because they are too comprehensive. In traumatism, as in the puerperal state, for example, there are several processes, each group of which may bring about mental disturbances more or less special to it, and not to traumatism or the puerperal state, which are wide and ill-defined expressions. The second idea is that the insane predisposition is not always and necessarily hereditary; since there are morbid causes which, while capable of creating it, so to speak, *de novo*, are apparently able to determine psychical disturbances without the aid of any other factor.

In dealing with the pathological causes of insanity the author lays special stress on the intoxications and infectious diseases. In France, as in many other countries, unfortunately, cases of alcoholic insanity are more and more numerous, especially in large centres, and while poverty is no doubt pretty frequently the cause of the increased consumption of alcohol, the license of distillers to sell spirits (often of an inferior kind) and the multiplicity of public-houses are largely to blame. Dr. Toulouse discusses in this connection the relation of general paralysis to alcohol, and raises the point as to the sub-division of general paralysis into varieties.

Under the heading of infectious diseases we find a good account especially of the relations of insanity to typhoid fever, influenza, and syphilis. Febrile or post-febrile insanities are comparable to those of intoxication, and there is in reality no special insanity to each acute disease. Between the insanity and the infectious diseases there are lesions of tissues and functional alterations, which are the true pathogenic factors (arising from fever, asthenia, intoxication), as connecting links, hence the importance in every case of studying the nature of the mental aberration, the character of the general disease, and the secondary lesions. In addition to this, while predisposition guides the localisation of the morbid process, the character and the temperament of the individual give the delusions their personality. The general considerations (p. 229-239) of the author on this subject are especially valuable, and the same may be said of those further on concerning the alternating physical and psychical disturbances in the "arthritic" diathesis—"arthritis" being, as is well known, an expression in favour with French pathologists, and applying to those diseases in which alterations of nutrition are predominant, metabolism

slow, and uric acid in excess. There is a good deal of evidence that it is especially in subjects of the arthritic diathesis that alcohol and syphilis the most easily bring about general paralysis.

In Book III. the author studies the rôle of predisposition and occasional causes in the evolution of insanity. That the notion of occasional causes has been pushed to extreme lengths is undoubted, for have we not had tubercular, hepatic, cancerous insanities described? Unfortunately this has had the result of checking the study of their influence in etiology, for, as Dr. Toulouse remarks, it is injudicious to fly to the other extreme, and declare that predisposition is everything, and that other causes have no influence in the genesis of psychopathies.

The day that we can find the anatomical substratum of a predisposition to a certain definite psychopathy we shall have made headway. At present all neuropathic antecedents are placed much on the same level of importance, whereas they may differ enormously in their influence. What are the anatomical and physiological sequences to toxæmias and other severe diseases? Morbid conditions, apparently very diverse, are undoubtedly closely related by exhibiting similar pathogenic processes which are capable of producing analogous psychical disturbances, so that, as Dr. Toulouse puts it, "there are no etiological psychoses, but pathogenic psychoses," and it is in the determination of the latter that lies our hope of advancing our knowledge of insanity. Moreover, when we label some insanities as cardiac, phthisical, etc., we forget that in pathology there is really no such thing as a cause, but there are etiological factors or conditions which are often very numerous. Very little reflection shows how complex the subject of etiology is, for assuming that in any case we have determined the anatomical substratum of a predisposition to insanity, and that peculiar to an occasional cause (such as typhoid, or syphilis, etc.), then all is not explained, for the patient has in himself a host of psychopathic determinants;—his character, his energy, his will, his intellectual attainments constantly give his mental symptoms their own *cachet*.

Finally, in Book IV. there are interesting suggestions concerning marriage, divorce, misery, alcohol, etc., in their bearing on the prophylaxis of insanity, and a chapter on the housing of the insane and drunkards. As regards alcoholics, Dr. Toulouse suggests that there should be special

asylums for all those who suffer from the craving after alcohol, and whatever be the viscus first affected (brain, liver, etc.), that they should be admitted only when free from mental disturbances (the insane alcoholic would be removed to this asylum when discharged from a lunatic asylum). They should remain here at least six months.

After a careful perusal of this book one can but congratulate the author on having produced a most valuable work of reference—not merely an olla podrida of dry facts relating to the etiology of insanity, but a well-planned and most interesting treatise. There is a most extensive bibliography, and the book is carefully indexed.

Les Caractères et l'Éducation Morale, Etude de Psychologie Appliquée. Par FRÉDÉRIC QUEYRAT. Paris. Félix Alcan, Editeur. 1896. Pp. 171. Price 2fr. 50c.

This small book, dedicated to Monsieur Ribot, is especially addressed to those whose task is the education of the young. It is an attempt to define character and to study its varieties; to point out the elements of character which it is necessary to cultivate or produce in education, and to indicate the means of furthering this end.

In 1843 J. Stuart Mill urged the scientific study of character under the denomination of ethology, and Alex. Bain was one of the first to bring out a special work on this subject—*Study of Character*—in which he distinguishes three fundamental types, the intellectual, the emotional, and the wilful or energetic. Since then much literature has appeared in this connection, to which the author briefly refers in his introduction.

M. Queyrat's definition of character is "a crystallisation of habits around a central nucleus which is the primitive temperament or disposition," and at the outset he analyses the two essential elements: the natural disposition and habit, and discusses the influence of heredity on character.

The classification of the forms of character (pp. 36 and 37) which he suggests is based on the predominance or the combination in varying degrees of the three essential psychical elements: the emotions, the intellect, and the will; and in Chapters II.-VII. inclusive we find a description of the different kinds of character which are met with.

a. To the first class belong those characters in which

there is a marked predominance of one particular faculty or tendency. In order to illustrate by examples the various types of character to which he refers, the author has introduced throughout the book, frequently with short sketches, the names of historical individuals, or celebrated names in fiction, with most happy results; for in addition to impressing his views upon the mind, the effect is to add a good deal to the enjoyment of his work. So that in this class for example we find mentioned as possessing the intellectual type of character, Newton, Leibnitz, Kant, etc.; the active type: sportsmen, the *condottieri* of the Middle Ages, the *conquistadores* of the sixteenth century.

b. In the second class are included characters constituted by the simultaneous predominance of two faculties; the passionate (or active-emotional) like Benvenuto Cellini; the sentimental (or meditative-emotional), Livy and Virgil; and the wilful (or active-meditative), Cato, Brutus, Frederic II. of Prussia, etc.

c. The third class includes those characters which are constituted by the harmonious combination (though in varying degrees) of the three faculties; from the well-balanced geniuses like Goethe, Descartes, Socrates, Marcus Aurelius, to the phlegmatic or apathetic type, of which Fontenelle was an interesting example, and the vulgar amorphous type distinguished by an equilibrium in mediocrity.

d. In the fourth class we find as characteristics an irregular or intermittent exercise of one or several tendencies. Among these we may place the unstable character as found in Casanova; the irresolute, of which Coleridge is a type; and the contradictory, so admirably portrayed by Molière in *Le Misanthrope*.

e. The class just considered (d) we may look upon as semi-morbid; but there are three further types, in reality pathological, which result, so to speak, from the hypertrophy of certain varieties above-mentioned, and which the author classifies under the heading of "morbid types"—(1) The hypochondriacal: Swift, Turner, and the notorious Jean Jacques Rousseau; (2) The melancholic: Cowper, Chatterton, Maurice de Guérin; and (3) The hysterical, so vividly typified by Madame Bovary, as painted by Flaubert in his wonderful psychological novel of that name.

In Chapter VII. M. Queyrat reviews the various characters considered, analysing their advantages and drawbacks, and, after comparing them with one another, he justly concludes

that the ideal to which one should tend is the realisation of the well-balanced character, in which the various faculties are harmoniously combined; one faculty may be, and often is, conspicuous, but the association with the other two sets it off to advantage, and at the same time acts as a check to its exclusive predominance.

The last chapter (Chapter VIII.) deals with the education of character. The author joins issue with men like Spinoza, Spencer, Ribot, etc., who doubt the power of education to modify character. "To conceive character as not modifiable by education is to proclaim the powerlessness and uselessness of morality." Fortunately the practice of humanity, the experience of pedagogues, and our own intimate experience, he adds, rebel against this view.

Tendencies are far from being unmodifiable; one can, for example, strengthen or repress an emotion, according as we give it or withhold from it satisfaction; and he instances the great change wrought in the character of the Duc de Bourgogne, grandson of Louis XIV. of France, by the influence of his tutors, notably of Fénelon.

In the process of education, M. Queyrat believes in the assistance which can be given by medicine and hygiene. He then makes important practical suggestions to the teacher as regards his dealing with the will and emotions of his pupils; to inspire sympathy, awaken feelings of ambition, cultivate affection, encourage self-reliance, etc., according to the disposition of the pupil, are some of his directions. Before all, it is indispensable that the nature of the character which one desires to influence should be thoroughly studied, in order that such and such a faculty should be either developed or checked as needs be.

Finally, in suitable cases and in proper hands, he holds it legitimate to try hypnotism in the reformation of character.

L'Idiotie—Hérédité et dégénérescence mentale. Psychologie et Education de l'idiot. Par le Dr. JULES VOISIN. Paris: Félix Alcan, Editeur. 1893, pp. 295, Fig. 17. Price 4 fr.

This book is based on a course of twelve lectures given by Dr. Voisin at the Hospice de la Salpêtrière, and should be useful to students and practitioners who desire to possess some elementary knowledge on the subject of idiocy.

It is cheering to read at the outset that Dr. Voisin

strongly holds the view that "instincts are transmissible, and modifiable by environment and especially education, and that such modifications are transmitted hereditarily," for there is no lack of those who hold that degeneration is fatally progressive. In discussing the causes of idiocy, our author acknowledges the frequent complexity of ætiology, but in the illustration which he gives of the influence of the psychological state of the parents at the time of conception on the mental condition of the future offspring he proclaims ætiology uncommonly simple.

A useful summary of the multiple lesions found in cases of idiocy is given in the third lecture, and prepares one to realise the difficulty of any attempt at defining or classifying idiocy. In this connection Voisin criticises and rejects the classifications which have appeared in succession, based on a comparison of the symptoms of idiocy with those of the development of the normal child, on a comparison of the intelligence of idiots with that of animals, or a comparison of idiots with various types of the human race, etc.; and, while doing full justice to Seguin's work on the education of idiots, he strongly combats his views as to the nature and psychology of idiocy. The organs of special sense are far from being necessarily imperfect as Seguin holds; indeed they are generally healthy, but the centres of perception are diseased. "It is the want of perception and ideation rather than absence of will which constitutes idiocy," he adds also, in opposition to Seguin's view that there is decided affection of the will in these cases.

Voisin's definition is: "The idiot is an individual whose intellectual, sensory and motor faculties are undeveloped or abnormally developed (in a defective manner), or else have been arrested in their evolution, before or a few years after birth, at a stage beyond which they cannot progress, as a consequence of various foetal or chronic lesions of the brain."

He classifies idiocy into four groups:—

1. Complete, absolute idiocy, congenital or acquired. There are two degrees: *a*. Anencephalous and those who do not even possess the instinct of preservation. *β*. Those who possess the instinct of preservation and certain habits. Some of these cases are strictly demented. Class 1 is incurable.

2. Incomplete idiocy, congenital or acquired. This class is susceptible of improvement; it includes several degrees,

according to the presence, absence, or range of certain intellectual, sensory, or motor faculties.

3. Imbecility, congenital or acquired—characterised by the presence in a rudimentary form of all the intellectual, instinctive, or moral faculties, and by the perversion or instability of these faculties.

4. Mental debility, characterised by the enfeeblement or the want of equilibrium of the faculties.

Cretinism or myxœdematous idiocy forms a separate group.

This classification is based on the psychology of idiocy and may be logical, but it strikes one as difficult of application in practice.

One point on which Voisin lays stress in various parts of his book is that every idiot presents associations of sensations and perceptions (usually very simple) and associations of affective states; these, however, are most important to recognise, for they guide us in the process of education. For the same reason it is necessary in each case to determine the state of the motor, sensory, and sensorial centres. Some idiots belong to the "visual" type, others to the "auditory" type, etc. Vision and touch are the most important senses.

The signs and symptoms of idiocy are dealt with in the fifth lecture. The author appears inclined to support Magitot in his conclusion that the longitudinal and transverse striæ observed on the teeth are rather stigmata of degeneration than evidence of syphilis, as is held by Hutchinson. The observations which Bourneville made on the genital organs of male idiots (and which led to a heated discussion at the "Conseil Municipal de Paris") have been carried on by Dr. Voisin in the case of female idiots, and his conclusions are, that in the case of female idiots, puberty is not retarded (Bourneville found the opposite in boys), and anomalies in form of the genital organs, which nearly always affect the glans of the clitoris and the nymphæ, are mostly due to masturbation.

In dealing with the senses of idiots, Voisin says that deafness is rarer among them than among intelligent people. This point is worth investigating by "ear and nose" surgeons, especially in view of the constant relation as cause and effect said by some to exist between nasal obstruction and a high palatine arch; for nasal obstruction is a frequent cause of deafness, and idiots have frequently high palatine arches. But is nasal obstruction common among idiots?

In connection with the blunted sensibilities of idiots, Voisin wisely emphasises the importance of watching closely for signs of disease in them, as objective signs are practically the only ones to guide us.

Nearly a hundred pages of the book are devoted to the psychology of idiocy and form interesting reading. Voisin incidentally remarks that his observations of idiots have led him to share the opinion of Kussmaul that ideas are often independent of words, and a study of their faculties of writing, reading, etc., leads him to the conclusion that there is in idiocy an inequality of development of different psychical centres and a relative independence from each other. Defect in one or other perceptive centre, or in the fibres uniting them, often explains various shades of difference in cases of idiocy or imbecility.

The last lecture deals with the treatment and education of idiots, and lays down the principles which should guide one in this work. Craniectomy is considered justifiable only in epileptic cases or in idiocy symptomatic of cerebral tumour.

One criticism (which unfortunately often applies to French works) should be made as regards the spelling of such names as *Gulls*, *Wirchow*, *Hutchisson*, *Orl*, etc., which stand for Gull, Virchow, Hutchinson, Ord, etc.

A History of the Chronic Degenerative Diseases of the Central Nervous System. By THOMAS KILPATRICK MONRO, M.A., M.D., Fellow of the Faculty of Physicians and Surgeons of Glasgow; Assistant Physician to the Glasgow Royal Infirmary; and Pathologist to the Victoria Infirmary of Glasgow; pp. 82. Glasgow: Alex. MacDougall, 68, Mitchell Street. 1895.

This work is part of a graduation thesis for the degree of M.D. of the University of Glasgow, and gives an account (which has been to some extent annotated by Professor Gairdner) of the various advances in our knowledge of the chronic disorders due to primary degenerations in the central nervous system. The diseases considered are tabes, primary spastic paralysis, ataxic paraplegia, hereditary ataxia, progressive muscular atrophy, bulbar paralysis, ophthalmoplegia, the peroneal type of muscular atrophy, and disseminated sclerosis.

It will be seen that this list, as indeed the author himself admits in his introduction, might have been easily extended;

but the treatment of the subjects mentioned, though somewhat unequal, is most interesting and well worthy of the perusal of every physician who is interested in the history of the progress of neurology, and of those who suppose that we have attained to finality in our knowledge of nervous diseases. This history shows by what slow, halting, and often backward steps our present standpoint of knowledge has been attained.

One fourth part of the work, about twenty pages, is devoted to the history of locomotor ataxia, or, as Dr. Monro prefers to call it, *tabes*—that most interesting of nervous diseases. We are glad to see that justice is done to the pioneer work of Todd in connecting the changes in the posterior columns with this disease; and that its priority to the publications of Romberg and Duchenne is noted. In the account of the disease each new step in our progress is carefully stated, and in such a way as to constitute this an invaluable work of reference to anyone studying the history of *tabes*.

The chapter on the history of progressive muscular atrophy is equally full, though not so long. The author mentions the little known fact that the first observer who really recognised the nature of the disease was an Englishman, Darwell, and not Duchenne, whose name it generally bears. On noting this one cannot help regretting that so much good work done in this country should sink into oblivion, and should not be rescued until some of our continental confrères have succeeded in gaining the credit of discovery. Dr. Monro traces carefully the steps by which the various forms of muscular atrophy, spinal, neuritic, and idiopathic, have been disentangled from each other. The chapter closes with a discussion of the relation of progressive muscular atrophy of anterior cornual origin to sclerosis of the crossed pyramidal tracts. The author inclines to side with Gowers's view that such a lesion is present in all cases. We would remark, in this respect, however, that Gowers quotes a case in which such lesion was wanting, and that Charcot's son has recently published a thesis which appears to establish the existence of an independent chronic disease of the anterior cornual cells.

On closing this work one feels a regret that there is not more of it, and one cannot but hope that Dr. Monro may be induced to publish the rest of his thesis.

Studies of Childhood. By JAMES SULLY, M.A., LL.D.
London : Longmans, Green, and Co., 1895. Pages
525. Price 10s. 6d.

In this handsome volume we find collected a series of essays on certain aspects of child-psychology, many of which have previously appeared in magazine form. The introductory chapter surveys the progress made since the time of Rousseau in the study of the mode of evolution of infantile intelligence, and we find references to the poetic and sentimental interest in the matter displayed by such writers as Wordsworth, R. L. Stevenson, Dickens, and Victor Hugo, as well as to the more exact observations of Sigismund, Darwin, Preyer, and Lionel Robinson. Professor Sully points out the peculiar interest to the psychologist of the "genetic tracing back of the complexities of man's mental life to their primitive elements in the child's consciousness," and rightly insists on the necessity of a scientific habit of mind in order to make observations and form deductions of real value. It is perhaps too much the fashion to think that nursery psychology may be practised without training in logical methods. Such casual observations of infantile phenomena are, however, apt to be fallacious; witness the traditional conviction of the Irish nurse that the pseudo-smile of the flatulent suckling proceeds from "visions of angels!"

In considering the play of infantile imagination, it is argued that imaginativeness does not exist in all children alike. Ruskin, indeed, has stated that when a child he was incapable of acting a part or telling a tale, a state of things we should not have predicated in the case of one so poetically gifted in adult life. It may indeed be argued that what passes current as exceptional moral rectitude, as in the familiar case of the great statesman who in childhood was incapable of lying, is but a mark of deficient imaginative power in early years. As Sully well remarks, "most children are at once matter-of-fact observers *and* dreamers, passing from the one to the other as the mood takes them, and with a facility which grown people may well envy." In extreme cases childish imagination may even lead, by transformation of sense impression, to a degree of momentary illusion. There is a constant tendency to assimilate the new and strange to the familiar, and what appear to us as pretty conceits are sometimes thus produced,

as when a child noticing dew for the first time, exclaims "Mother, the grass is crying!" The power of making everything out of nothing is referred to by Ruskin as the "perfection of child-like imagination," and will explain much to the careful observer of the spontaneous play of a child. Perhaps we may add that in processes of dissolution of higher faculties, such as we see in the insane, we have examples of reversion to primitive modes of mental action.

In considering the dawn of reason, it is remarked that as a rule the earliest observations made by an infant are partial, that is to say, restricted as regards direction, though they may be minute so far as they go. Thus colour is often more impressive than form, as in the case of the eighteen-month-old child who called black lambs "doggies" and white lambs "lambies." Comparison not only of form and colour through the eye, but (as we would add) of contrasting tactile impressions in quite young children, is "of the very essence of understanding."

"The questioning age" is said to be ushered in with the fourth year, though casual interrogation may commence as early as the third. The "what," the "why," and (as Marie Corelli reminds us in *The Mighty Atom*) the "whence," form successive stages in the child's thirst for knowledge, and the parent must not try to repress the inquisitorial zeal of the budding intelligence. Most children have practical instincts, and are prone to speculation as to how things are made, be they beans, birds, or babies. "I want to know who made God, and I want to know if pussy has eggs to help her make ickle kittens?" was the puzzle propounded by a four-year-old philosopher to his bewildered mother! Questioning must not be looked on as mere "cussedness," as the tendency, if tiresome, is of important educational value; but in some cases reiteration of answered queries, as observed in feeble-minded children, seems to denote deficient attention, and should not be encouraged.

Chapter IV., which treats of the products of child thought, is specially interesting, more particularly where it traces the child's thoughts about nature. The tendency to "reify," or make things of, visual impressions may be early noticed, as when a two-year-old child tries to touch shadows, or to "gather sunlight in her hands and put it on her face." The interest in movement displayed by all children is often associated with a disposition to interpret seeming self-movement as a sign of life, so that balls, hoops, &c., not to mention

locomotives, fire and smoke, are spoken of as possessing vitality. Children's ideas are essentially anthropomorphic, and we have from an American source a tale reminding us of the old Norse myths, a child's explanation of thunder as the noise of a loal of coals being run in for the Deity! Homely conceptions of theology are illustrated by the question of a little girl of four, "Isn't there a Mrs. God?" Professor Sully is of opinion that children of three and four are "for the most part simply confused by the accounts of God which they receive."

Chapter V., entitled "The Little Linguist," traces the gradual evolution of speech from pre-linguistic babblings. It would appear that from mere cries the first step towards articulation is the formation of open sounds like *oo* and *ā*. Then comes *la-la-ing*, afterwards simple labials, though with certain children guttural sounds. Reduplications of sounds successfully attempted are common, perhaps from physiological inertia, but more probably from the pleasure of self-imitation and of simple rhythmic effect. Gesture language precedes articulate speech, and it is argued that there is a spontaneous expressive articulation out of which language grows, the former being often original rather than imitative, as when Darwin's boy employed the sound "*mum*" to indicate food, afterwards calling sugar "*shu-mum*" and liquorice "*black shu-mum*." Among imbecile children, necessarily somewhat isolated from the family, we have known quite an original vocabulary evolved with a philology of its own. The order in which words are used with due appreciation of their meaning is very interestingly illustrated, and the child's early struggles with the irregularities of the English language are pathetically described. The misinterpretation of words, as "average" being "what the hens lay on," and misconception from similarity of sound, as of the boy who persistently used for the opening petition in the Lord's Prayer "*Harold* be thy name," are amusingly instanced.

The feelings of children form the subject of the next chapter. It is stated that while apparent manifestations of fear are well marked in the young child, it is possible that to some extent these are reflex rather than mental. The startling effect of sounds, and the disconcerting effect through the eye of changes of surroundings, are discussed as factors of mental uneasiness, as are also the fear of animals, the fear of the dark, &c.; and it is pointed out

how large a share imaginativeness has in the production of terror. "Primitive egoism" is dealt with in relation to the raw material of morality. Sully's doctrine is founded upon the observation that "for some time after birth the child is an incarnation of appetite which knows no restraint," and the removal of the feeding-bottle before satiety is reached is referred to as the first step in the thorny path of self-denial. Anger and cruelty are discussed; and it is pointed out how curiosity is often the determining factor of destructiveness. Altruism, as shown by sympathy with, and a disposition to aid, others, is of course a later development arising from instinctive sociability, which is normal with the majority of children. Children's lies are sometimes traceable to a natural tendency to secrete things, sometimes to a predominant imaginative power.

The struggle with law forms the subject of the eighth chapter. It is shown that in the child there are compliant as well as non-compliant tendencies towards law and authority, but much depends upon how the latter are asserted. "To expect the right thing, as though the wrong thing were an impossibility, rather than always to be pointing out the wrong thing and threatening consequences" is the most judicious line of discipline, and will be followed by the most practical results. The action in moral training of a quasi-hypnotic suggestion, as in the inspiring dictum "You *can* do it if you try," is justly commended.

Our space precludes us from following in detail the chapter on "The Child as Artist," with its amusing original illustrations, or commenting on the voluminous "Extracts from a Father's Diary," but we have said enough to indicate that the book is a mine of wealth, from which many valuable hints may be derived by those practically or theoretically interested in the psychological development of childhood.

La Sociologie Criminelle. Par HENRI FERRI. Paris: Rousseau. Troisième édition. Pp. 648. Price 10 francs.

Criminal Sociology. By ENRICO FERRI. (The Criminology Series.) London: Fisher Unwin, 1895. Pp. 284. Price 6s.

This work—of which the chief chapters have lately been presented to readers of the Criminology Series—is one of five books on which the modern criminological movement may be said to rest; the first and best known of these is, of

course, Lombroso's *Uomo Delinquente*; another is Marro's *Caratteri dei Delinquenti*, a monument of patiently elaborated original work which can never be popular, but deserves to be considered a classic; another is Ferri's own wonderful and complete study of homicide under all its aspects, only recently published; the fourth is Garofalo's *Criminologie*, dealing with the legal aspects of criminology. Of all these works, the present, although it has hitherto been little known in this country, is perhaps the most generally interesting and the most ably presented. As an introduction to the views of the Italian school it should most certainly be read before any of the others. The author is a professor of criminal law, who is at once an accomplished anthropologist and a philosophic sociologist, warmly sympathising, however, with the advanced movements of the time. These sympathies have indeed lately led to his retirement from his chair at the University of Pisa, and to the assumption of professorial duties at the new Free University of Brussels. He is at the same time no hot-headed revolutionist, but a man of grave and sedate cast of mind who approaches every problem with the temperament of the philosopher, and seeks always to see it steadily and see it whole. And he is, finally, a master of eloquent and lucid exposition. A man who combines so many rare and admirable qualities should be able to present the views of the Italian school in the most attractive light. The reader of this book—preferably in the unabridged French edition, translated by the author himself—who remains unconvinced may certainly rest assured that the fault lies either with the ideas or with himself, not with the expositor.

Putting aside short introductory and concluding chapters, and a fairly full bibliography occupying some fifty pages, the work consists of four main chapters. The first attempts to present, in a clear, brief and reasonable shape, the chief data of criminal anthropology. The next deals similarly with the data of criminal statistics. These two chapters occupy about half the volume. The next two chapters, which occupy most of the rest of the volume, are more constructive and original, and treat the positive theory of responsibility and the question of practical reforms.

It will thus be seen that Ferri deals very broadly with the great problem of criminality. His main point is that it must be so dealt with; he protests from first to last against

the methods of the "classic school" by which crime is treated as an abstract entity, and the criminal, with all his peculiarities, entirely ignored. In this matter what we call law or justice is simply a name for the inevitable "social reaction" against criminality. Society must see to it that this social reaction is reasonable and efficacious. We are helped to do so, Ferri believes, if we always translate, actually or mentally, our current terminology into terms of social reaction, and instead of speaking of crimes and punishments speak of offences and defences. He illustrates this point effectively by a reference to insanity. The social reaction involves an inevitable defence against the insane. But up to the end of the last century that reaction took the absurd form of punishment and contempt. We still treat our criminals with punishment and contempt. And it has proved to be equally unreasonable, equally ineffective. The time is coming, has indeed actually come, to do for the criminal what Tuke, Pinel, and others did for the insane. Hence the immense importance of Lombroso's identification of "moral insanity" with "instinctive criminality." Madmen and criminals have been brought into line. They are both beginning to be recognised as members of the same great family of abnormal, degenerate, anti-social persons. This point will remain unshaken, whatever disputes may occur on matters of detail. Henceforth the wrangles of lawyers, founded on extinct metaphysical notions, have become mere child's play of no scientific importance. Practical importance, it is true, they still retain. It thus becomes the duty of the scientific alienist to set his house in order and to see to it that he does nothing to perpetuate these notions. "Every man is responsible for his actions because, and so long as, he lives in society." Responsibility means that a man suffers the consequences of his actions. The social reaction against anti-social actions is a primitive and inevitable fact of all social life. But it is in our power to shape this inevitable social reaction. We may ameliorate the conditions that produce anti-social action, treat the anti-social person in such a way that he may cease to be anti-social, and in the last resort we can place him where he is unable to gratify his anti-social instincts. To attain these ends society must work through the lawyer and the alienist, acting in conjunction. The chapter on practical reforms deals with some of the chief methods for attaining these ends. With most of them—social amelioration, reparation

by criminals, conditional liberation, indeterminate sentence, —we are now fairly familiar.

Criminology, thus regarded, while remaining a juridical science, becomes a branch of sociology, based on anthropology (with psychiatry) and statistics.

This brief summary fails to do justice to Professor Ferri's cool and logical elaboration of his main thesis, but it may serve to show how he develops the wide social issues of the alienist's work, and may help to call the attention of English readers to this remarkable and important work.

The translation in Mr. Morrison's Criminology Series is as careful and competent as that of Lombroso's *Female Offender* with which the series opened. It is, however, very incomplete. Only the three most important chapters are presented, and that in a very abbreviated version, and with a general omission of references. Several chapters are wholly omitted, as well as the bibliography, and there is no index. But the translation will be useful to those who wish to obtain, with a minimum expenditure of energy, a brief authoritative statement of the chief contentions of the Italian school.

Outlines of Psychology. By OSWALD KÜLPE. Translated by E. B. Titchener. London, 1895. Swan, Sonnenschein. Pp. 462.

Thirty years ago England, with its observational school of psychology, founded largely on the doctrine of association, was ahead of Germany and the world generally. Since then a new movement has arisen in Germany, which has placed that country indisputably at the head, while England remains almost in the same position as before, and it would be difficult for Ribot to add any important chapter to his memorable history of English psychology. One of the results of this new balance of power in European psychology is that we in England have to depend on the Germans for the exposition of the new psychology. It is true that the Americans are devoting themselves to experimental work, but they appear too busy in their well-equipped laboratories to find time for lucid and comprehensive exposition. (James and Ladd may seem to be exceptions, but while largely interested in experimental psychology they belong by training and sympathy to an older school; this is true even of Baldwin, as of Sully and Morgan in England.) This is an unfor-

tunate state of things, for not only is the German usually unfitted to make an effective appeal to the Englishman, but he has always been notoriously inapt for the expositor's work.

It cannot be said that Prof. Külpe's *Grundriss der Psychologie*—though very competently translated by Prof. Titchener, of Cornell University—does much to alter this position of affairs. The author, although for a long period Wundt's chief assistant at Leipzig, possesses neither the attraction which must always belong to a great original investigator like his master, nor the charm of a skilful expositor. Moreover, although on the title-page the book is said to be “based upon the results of experimental investigation,” these results themselves are only recorded in the very baldest and vaguest shape, and even the references to the literature which contains them is extremely inadequate. The book is *doctrinaire* and attempts to force facts into a system, for which the way is yet scarcely clear, so that while undoubtedly based upon experimental results, its tendency is to run into that premature methodism against which all experimental psychology is a protest.

Although Külpe's starting point is in Wundt, he by no means follows Wundt closely, and on many points departs from him widely. His work thus has the advantage, and the disadvantage, of being a fairly independent and original presentation of the problems of psychology. The most striking and fundamental point in Külpe's psychology is the thorough-going and systematic manner in which he uses sensations as the “elements of consciousness,” from which nearly the whole structure may be built. In this no doubt he illustrates an interesting and important tendency in contemporary psychology, although his method of working it out is his own. Sensations, with their four attributes of quality, intensity, duration and extension, occupy the greater part of the work. Memory and imagination are “centrally excited sensations.” Feeling, indeed, is an independent conscious process, which accompanies sensations under given conditions. Külpe refrains from regarding feeling as an attribute of sensation, largely on the logical ground that it is inadmissible so to count a process which is itself possessed of the attributes which belong to sensation. Emotions and impulses, however, consist of feelings added to sensations. No doubt the best, as it is much the largest, part of the book is that concerned with the specific senses and the

discussion of the fusions and colligations of sensations as usually understood. A very short part deals chiefly with attention and will (explained chiefly by apperception), and hypnosis and sleep are briefly dismissed in the concluding section.

It cannot be said that the book is a model text-book, even if it can fairly be described as a text-book at all. Nor is it written with any special reference to the interests of psychiatrists. While, however, it cannot be recommended as an introduction to experimental psychology, Prof. Külpe's work is not one to be ignored by those who are keenly interested in psychological problems. It is the work of a fairly vigorous and independent thinker, and no fellow-worker will fail to derive some stimulus from it.

L'Année Psychologique, 1895. Publiée par MM. BEAUNIS, BINET, RIBOT, HENRI, etc. Paris: 1896. Alcan. Pp. 1010. Price 15 francs.

The second issue of this admirable year-book is even better than the first, and considering its size it is issued with praiseworthy promptitude.

The volume is planned in much the same way as the first, but the sub-divisions are more numerous, and they are better filled out with useful matter. The first 500 pages are devoted to original work under the three headings of "Memoirs by Collaborators," "Investigations carried on at the Paris Laboratory of Experimental Psychology," and "General Reviews." The Memoirs include a brief study of character in the various stages of abnormal and morbid progress towards complete degeneration, dealing also with the question of "temperament" (Ribot); a rapid survey of comparative psychology, reaching views opposed to those of Wundt (Forel); a note on reading-time (Flournoy); a study of the conditions favouring hypnosis in animals (Gley); the measurement of illusions of weight (Van Biervliet). Among the laboratory studies we find one of an elaborate but still incomplete character on the capillary circulation in the hand in its relation to respiration and to psychic acts (Binet and Courtier); researches on the localisation of tactile sensations (Henri); an application of the graphic method to piano-playing as a study in the psychology of movement (Binet and Courtier); a study of fear in children

and its treatment (Binet). The "General Reviews" include Histological Psychology and the Texture of the Nervous System (Azoulay); Cutaneous Sensations of Locality (Henri); the Psychology of Smell (Passy); a review of the important question of individual psychology (Binet and Henri); and a mathematical paper on the calculus of probability in psychology.

Then follows the full and well-arranged section devoted to critical analyses of the chief books and papers during the year. A considerable portion of this part is concerned with abnormal and morbid psychology, and it is altogether of great interest and value. The illustrations number about 140. The volume ends with the Bibliography, containing nearly 1,400 entries. By a sensible arrangement *L'Année Psychologique* has here joined forces with the *Psychological Review*, and utilises the work of Mr. Farrand and Mr. Warren. The proper plan is now adopted of making each entry in untranslated form.

The only suggestion we can offer for the improvement of the year-book is that in future it should be issued in two volumes. Original work occupies exactly half of the present rather cumbersome volume, and while of undoubtedly excellent quality it is much less indispensable for use and reference than the second half of the volume, and might more conveniently be issued under a separate cover.

In any shape the work is of great value for psychologists in every field. That this fact is generally appreciated is shown by the statement that the issue for 1894 is now exhausted, with the exception of a few copies which may be obtained from M. Binet at double the original price.

Thinking, Feeling, Doing. By E. W. SCRIPTURE, Ph.D.
Philadelphia and New York: Flood and Vincent.
1895. Pp. 304. Price 4s.

This book—which has circulated, it is said, by tens of thousands in America—has excited much criticism among psychologists of the sober and old-fashioned school. Dr. Scripture is one of the ablest of the younger psychologists; his name is well-known in connection with various highly technical investigations; he is the director of the psychological laboratory at the venerable Yale University; and in this book he has attempted to bring the methods and

results of experimental psychology into the streets, and to carry them down to the level of the meanest intelligence. With the help of a journalistic style, interspersed with jokes and profuse illustrations (there are 209 in this small volume), also occasionally of a comic character, Dr. Scripture courageously attempts to achieve popularity. The coloured frontispiece presenting five pictures of the American flag as it appears in various kinds of colour-blindness, is characteristic of the book. In the preface the author writes: "This is the first book on the *new*, or experimental psychology, written in the English language. That it has been written *expressly for the people* will, I hope, be taken as evidence of the attitude of the science in its desire to serve humanity." In this object he appears to have succeeded beyond all reasonable expectation, and while some objection may be raised to the style of exposition here adopted, there should not be much doubt that the author has done something which was well worth doing, and which he was very competent to do. The book is fragmentary, but it covers all the more important and interesting departments in psychology: reaction-time, "thinking-time," attention, touch, smell, taste, colour, hearing, feeling, emotion, memory, rhythm, etc. The last chapter is a brief historical sketch of "the new psychology," culminating in a brief account of Wundt, "the greatest genius in psychology since the time of Aristotle." The profuse illustrations (process-blocks and diagrams) are sometimes futile, but on the whole extremely helpful to the text. Dr. Scripture adopts a style of oracular infallibility which we are not altogether accustomed to associate with psychology, and which is certainly ill-adapted to inculcate the scientific spirit, but on the whole (though not always) the matter brought forward is fairly non-contentious. As a very simple exposition of the methods and results of experimental psychology, the book is admirable for students of the university extension order; while for all those who are ignorant of modern laboratory psychology it will prove of much interest. Adult readers must forgive Dr. Scripture his magisterial superiority and his attempts to satisfy their supposed craving for innocent amusement and mild jocularitv, but if they can do so they will find him a reliable guide.

Jeanne Darc. Vom psychologischen und psychopathologischen Standpunkte aus. Von Jos. ZÜRCHER. Leipzig. 1895. Pp. 147.

This is a dissertation for the doctorate at Zürich, and the authoress was largely inspired by Prof. Forel, whose influence may be traced throughout. The book is perhaps somewhat overweighted by general discussion of hypnotic and other phenomena.

Dr. Zürcher, in analysing the facts concerning Jeanne which have come down to us, desired to do justice both to her genius (considering her the first among women of genius) and to the many elements of morbidity which she presents. Jeanne's first vision occurred when she was thirteen years old; she heard a voice, and saw a bright light when in her father's garden one summer day, after fasting for twenty-four hours. The voice was not shaped into intelligible words. This, the authoress remarks, can scarcely be called a hallucination; it was a mere paræsthesia due to exhaustion and fatigue at the period of puberty. But soon the voices became distinct, and the visions grew constantly more definite and elaborate, becoming most frequent during her final imprisonment. Dr. Zürcher lays stress on auto-suggestion as the chief factor in the development of these hallucinatory phenomena, and seeks to analyse the contents of this auto-suggestion. It is put down largely to national tradition which asserted that France would be saved by a pure maiden from the oak forests of Lorraine (whence Jeanne came). She denied that she was so influenced, perhaps because the influence was unconscious, perhaps because her mission would thus have been prejudiced, since the forest was associated with sorcery. The hallucinatory aptitude grew and flourished on the basis of this auto-suggestive process, and at the time of her death the hallucinations had attained an extraordinary degree of development, doubtless assisted by Jeanne's constant fasts and devotion to religious duties. She had at last "completely identified her ego with the ideas she had assimilated." There were hallucinations of touch, taste, smell, and common sensation, as well as of hearing and sight. Dr. Zürcher considers that there were also illusions since the voices frequently came with the sound of the vesper bell. The point is not, perhaps, very important, but it may be pointed out that in paranoia and

allied conditions similar monotonous or indifferent sounds frequently stimulate the production of subjective voices, from which, however, they are recognised as quite distinct, and thus no illusion can properly be said to be present.

These phenomena are undoubtedly morbid. At the same time Dr. Zürcher holds that when we consider them in relation to Jeanne's time they lose something of their morbidity. She also points out the extraordinary extent to which auto-suggestion may be carried in a man of genius without rendering him liable to the charge of insanity; a few pathological traits have even been helpful to men of genius. She remarks, further, that recent researches in hypnotism have greatly reduced the gravity attaching to an aptitude for hallucination; and had she been acquainted with the latest volume of the *Yale Psychological Studies* she might have added that Dr. Seashore's remarkable experiments have now shown that even the normal scientific worker in the laboratory is exposed to hallucinations due to auto-suggestion. The conclusion reached by the authoress is, therefore, that although Jeanne distinctly passed beyond the bounds of the healthy and normal, she was not insane in the ordinary sense of the word; her case belongs to the pathology of genius.

Although somewhat vaguely and imperfectly worked out, this little study is not without interest.

On the Temperature of the Brain. By A. Mosso. *Die Temperatur des Gehirns, Untersuchungen, mit einem Titelbilde und zahlreichen Abbildungen im Text und 5 Tafeln.* Leipzig: Veit and Co. 1894, 191s. (Investigations on the Temperature of the Brain, with numerous Woodcuts in the Text and five Tables, by A. Mosso).

We avail ourselves of the abstract of this work, given by Dr. F. Kiesow in the *Zeitschrift für Psychologie und Physiologie der Sinnesorgane*, Heft ii., Band 9, 1895.

Mosso's investigations were made on marmots, dogs, monkeys, and human beings. The temperature was ascertained by means of a delicate thermometer which gave to the naked eye a reading of 0.01° . In the experiments on animals the thermometer was included in a steel tube which was pushed through the trephined opening in the skull. In the human subject the temperature of the rectum was noted at the same time as that of the brain. The temperature of

the arterial and venous blood in the carotids and jugular veins was also ascertained in the experiments on animals. In these cases the position of the thermometer was verified after death.

In man and dogs there was found to be a greater difference between the temperature in the brain and in the rectum in winter than in summer. In curarised dogs it was ascertained that the brain lost heat by radiation sooner than the rectum. In asphyxia a rise of temperature in the brain was observed. The irritation of the brain caused by the introduction of the thermometer was attended by a rise of heat of short duration both in the human subjects and in animals. In some cases the brain was found to be colder than the arterial blood. Mosso thinks that the quantity of blood flowing into the brain is not sufficient to raise the temperature to blood heat. As the venous stream carries away heat, the arterial blood would always be warmer than the brain, were the temperature of this organ not raised by a chemical process in the ganglia. The author attaches great importance to the independence of the thermic processes in the brain. Sensations, tetanus, and convulsions can take their course unaccompanied by any rise in the cerebral temperature. He assumes that there is a store of chemical energy in the brain whose transition into heat does not run parallel with the psychical and motor functions. There is in the brain both a nutritive and a functional chemical process. Mosso considers it possible that the substances which generate heat do not serve the trophical processes of the nerve cells, but that they are consumed without helping the psychical and motor functions. The induced current, after section of the spinal cord, caused a rise of temperature in the brain which was sometimes followed by a lesser rise within the rectum. In the same way the electrical stimulus acts upon the zone of Albertoni. Although epileptic fits are thus excited in the dog, Mosso holds with Brown-Séguard (*Comptes Rendus*, 1892, September 12th) that the centre for epilepsy does not lie in the brain cortex, but that the irritation is propagated from the brain to other centres which bring on the epileptic attack. Narcotics diminish the facility of exciting epileptic fits.

Experiments were made upon the effects of cocaine, atropine, alcohol, strychnine, coffee, and absinthe upon the temperature of the brain. The animals were curarised to exclude muscular contractions. Curare and chloroform were

found to neutralise the thermic action of cocaine. The return of consciousness after chloroform caused the brain temperature to rise. Again and again does Mosso insist upon the independence of the temperature in each organ of the body. The author gives the name of organic conflagration to the thermic activity which is separable from the periods of motor and psychical activity.

This organic conflagration represents the heat evolved in the metabolic phenomena which follow the specific functions of the different organs. This production of heat is facilitated when the excitability of the brain is increased. Mosso thinks that the basis of psychical activity consists in a molecular movement in the brain cells, and should this energy pass into motion a certain quantity of heat is set free. Anæmia, ischæmia, and asphyxia also arouse heat in the brain. There is no increase of temperature after voluntary motions, and even weak electrical currents applied to the motor region of the cortex do not raise the heat of the brain.

Mosso made observations upon the cerebral temperature in an idiot of two years of age in whom trephining of the skull had been practised; on Delphina Paradi, a girl of twelve years who had a wound in the skull on the right side; and also on Cane Luigi, a mason aged forty-five, who suffered from a defect of the cranium over the posterior part of the temporal lobe. In the idiot the thermometer could be introduced in the direction of the fissure of Rolando; in the girl into the fissure of Sylvius; and in the last case the author tested the changes of the brain through a Marey's drum, comparing it with alterations in the circulation of the arm with the plethysmograph. In the idiot it was ascertained that strong motions and cries caused no rise of temperature in the motor region of the brain. In Delphina's case neither mental nor motor exertions had any influence upon the brain temperature, but emotions such as fear for the administration of chloroform caused a rise of temperature of 00·1. The return of consciousness after chloroform was not accompanied by any development of heat in the brain. In the third subject, the mason, it was shown that a pleasant mental excitement brought a larger flow of blood to the brain than simple speaking. The temperature in the rectum did not rise simultaneously with that in the brain. A small degree of apnoea causes a great increase in the volume of the brain. The alterations in the circulation in the brain and the ex-

tremities were not always of an opposite character to one another.

The author does not think that the plethysmographic curves in the brain are always dependent upon alterations of pressure in the arterial system.

Mosso has made some experiments upon normal and artificial sleep in man, dogs, and the winter sleep of marmots. He found that in this hybernating animal the brain had a lower temperature than the chamber in which it lay, nevertheless the temperature in the brain was higher than in the other organs, and chemical processes were more active. On applying mechanical and electrical stimuli to the brain of the marmot in the lethargic state there was a rise of temperature.

Paralisi Progressiva e Frenosi Sensoria, Lezioni Cliniche dettate dal Prof. L. BIANCHI. (General Paralysis and Psychoses Originating in Disturbances of Sensation. A Series of Clinical Lectures delivered by Prof. L. BIANCHI.) Naples, 1895.

In response to the request of his students Prof. Bianchi has published these lectures. The subject of general paralysis of the insane absorbs rather more than one half of the brochure. Lecture I. treats of the etiology of the disease, and we note that, in reference to heredity, whilst recognising that, in the greater number of cases, no history of heredity of nervous and mental disease is forthcoming, the author regards neuropathic heredity as a factor of great importance, which in many cases is the only cause of the disease. Reference is made to the occurrence of general paralysis in families; in one family no less than 11 members were affected (Goldflam). Insolation is regarded as a cause, an instance being described. Some importance is ascribed to sexual excess. The author deals at length with the vexed question of the relationship between syphilis and general paralysis, detailing the views held by various writers, and adducing their statistics. He himself does not ascribe to syphilis the etiological importance claimed for it by certain authors. The following are amongst the considerations which he submits in reference to this question: The anatomical signs of cerebral syphilis are conspicuous by their absence in autopsies of general paralysis: the great increase in the disease of late years is

not explained by contemporaneous increase in the frequency of syphilis; the increase in the female sex cannot be due to the increase of syphilis in the latter, but is rather to be explained on the theory that women are partaking to a greater extent in the struggles of men; whilst general paralysis is rare amongst the Arabs, syphilis is not, it appears, rare; anti-syphilitic remedies are useless, or worse than useless, even though they remove syphilitic manifestations which happen to be present in the patient; neither clinically nor from an anatomico-pathological point of view is there any difference between cases with syphilitic history and those without. From the various considerations which he adduces the author is led to the conclusion that syphilis acts, in common with many other factors, rather as a predisposing cause, by weakening the resisting power of the nervous elements. The remaining etiological considerations with which this lecture deals call for no special reference here.

Lecture II. deals with symptomatology. The author distinguishes four classes, amongst which he recognises the exalted and the melancholic. In the third variety somatic symptoms are first noticed, or predominate—disturbances in cutaneous sensibility; but especially defects in spoken and written language—this is the most characteristic symptom. Later come tremor, and alteration of reflexes, and then the mental symptoms. The fourth group comprises cases in which (the health till then having been excellent) slight symptoms, attracting but little notice (such as giddiness, headache, confusion, irritability), appear, and are suddenly followed by an apoplectic or epileptic attack, to which succeed the usual symptoms of paralytic dementia.

Lecture III. deals further with symptomatology, and is illustrated by typical cases of the various forms of the disorder. Differential diagnosis is duly considered.

In Lecture IV. somatic symptoms are specially considered. In regard to the state of the pupils, certain results arrived at in the author's clinic are given, and are as follows: Out of 47 cases the pupils were equal in 27, unequal in 13. In 25 the pupils reacted to light and accommodation. Pupillary disturbances occurred in more than one-half of the cases. In about one-third differences in light reaction between the two sides existed. Diminished acuteness of vision was very frequent; it occurred in 40 out of 47 cases.

Colour-vision was also disordered. Various other results are also given appertaining to the state of the visual field and of the disc. Referring to the tendon-jerks, the author points out that their varying condition is related to the presence or absence of tabes, depending upon the time of appearance and course of the latter. It is pointed out that no less importance attaches to the abolition than to the exaggeration of the jerk. In the remainder of the lecture the chief of the manifold somatic symptoms of this protean malady are detailed.

Lecture V. deals with pathology and pathological anatomy. The rival theories of inflammatory and degenerative origin are discussed. We note that the author, whilst referring to the proliferation of the connective-tissue elements, and quoting Bevan Lewis as a supporter of the inflammatory theory, does not give the well-known views of this writer as regards the rôle of the morbidly developed connective tissue elements. We refer to the "scavenger-cell" theory. It is extraordinary that these suggestive views receive such tardy and scant notice from foreign observers.

The author remarks that the degenerative process which characterises the disease is not limited simply to the nervous system, but that all other organs are more or less involved. He quotes results observed in a large number of cases in his own institution in support of this statement. With regard to the kidneys, the frequency of lesions in them is duly recognised, and reference made to their influence in the symptomatology of the disease. It is not, however, contended, with certain recent writers, that the disease is essentially an arterio-capillary fibrosis. In the further observations upon the pathology of the disorder, with which Lecture VI. opens, we find nothing of special note. The author does not enter into such theoretical considerations as the possible bacterial origin of certain of the phenomena occurring in the course of general paralysis, such as hæmatoma auris, subdural hæmorrhage, and of certain of the phases of the disease. Such controversial points are not, however, avoided on principle, since like matter is dealt with elsewhere in the work. We believe that these are questions which will demand careful study in the near future.

The question of differential diagnosis receives due consideration. So-called "pseudo paralysis" the author disbelieves in. He refers to two cases of hysteria in which

the diagnosis from general paralysis afforded real difficulty. The course of the disease is put at from a few months to ten or more years, these great variations depending upon the nature and chief *locale* of the disorder, and upon the resisting power of the individual.

With reference to treatment, the author records his opinion, which is in keeping with the general teaching, that mercury is of no use, and is sometimes harmful. Ergot is spoken of as a remedy of some benefit in "congestive states." Referring to trephining, the author remarks that a temporary relief of cerebral compression is the most that can be expected therefrom. The various methods employed at the present time for the relief of symptoms are related.

The second portion of the work is devoted to the subject of psychoses, "which originally and essentially are characterised by sensory disturbances (hallucinations and illusions)." After preliminary observations upon the distinction between sensory images and abstract ideas, and upon various hypotheses bearing upon the genesis of hallucinations—and in this connection the mechanism of physiological and subjective perception is, as far as our knowledge goes, explained—the author elucidates the general conception of the "Sensory Psychosis." This condition, always represented by hallucinations, principally auditory and visual, may sometimes for a certain period be exclusively so represented; subsequently abnormal intellectual and affective states are provoked. The malady, it is observed, has not been clearly delineated by systematic writers, having been confused with other disorders; some, indeed, do not even mention it. We are certainly not aware that in this country the group of symptoms described in these pages are accorded a distinctive place in nosology. The cases are divisible into three groups. The first comprises cases in which false perceptions are the starting point of the disease, which form the author calls "*frenosi illusionale o percettiva*." Secondary to this sensory disturbance the mind becomes disordered, with alteration of character, of the entire personality. Brains so altered may be said to be "vulnerable" at the outset, by reason of neuropathic heredity or excesses. In the second group are comprised cases in which a vivid hallucination surprises the mind, until that time acting normally, and in full vigour, apart from the predisposition already spoken of, which is present in most of these cases. Upon this is established a delirium, a stupor, or a melancholy; a veritable

systematised delirium may develop. In the above groups the sensory disturbance is intense; it is not at all necessary to the persistence of the mental disorder induced that this disturbance should be repeated. In the third group, individuals of mental constitution sufficiently strong are affected by hallucinations, not specially vivid, but variegated, and which may be repeated over a very long period without disturbing the mental organisation. From the numerous references to foreign writings, and from the author's own cases, it is clear that the most prominent variety of the "frenosi sensoria" (initial sensory disturbance, subsequent mental confusion, stupor) is identical with the state which in this country is designated "acute dementia." What the author particularly emphasises—in contradistinction to many writers—is that, if not in all, then certainly in the majority of cases, the confusional or stuporose state has been preceded by a period of hallucination. The duration of the confusional state varies from weeks to months, or even years. The author goes on to demonstrate that the primary hallucinatory state may give rise to a systematised delirium (paranoia), which teaching is altogether at variance with that of Krafft-Ebing. He differentiates between cases of paranoia in which the disturbance is primary, and hallucinations (if present) secondary, and those in which the primary disturbance is in sensory areae, delusions arising secondarily therefrom. In the author's view the greater number of cases of paranoia belong to the latter group. The psycho-physiological mechanism by means of which it may reasonably be supposed the original sensory disturbance induces mental disorder is described, and a scheme is given which serves to show in graphic form the routes by which stimuli (neuro-luminous "waves") pass in ocular perception. This helps the reader to conceive the mechanism of perception, judgment, and reaction, and the corresponding nexus for hallucinations, mental confusion, delirium, and impulsive manifestations.

Turning to pathology, the author makes the interesting statement that from the blood of certain of these cases of acute sensory delirium ("frenosi sensoria acuta") pure cultures of streptococcus pyogenes, or, in others, of staphylococcus aureus were obtained, which produced death when inoculated into the cranial cavity of animals experimented on. The urine of these animals, injected into like animals, was fatal.

The concluding pages are occupied with differential diagnosis, prognosis, and treatment of "frenosi sensoria." The diagnosis is drawn between the sensory psychoses on the one hand, and mania, general paralysis, melancholia, paranoia, and acute delirium on the other. As regards prognosis, it is noted that the acute form of the disorder is a grave malady, sometimes threatening life. The recovery-rate is put at about 40 per cent. Apart from recovery or death the disorder passes into dementia or secondary paranoia.

From amongst the therapeutic measures suggested we single out electricity, in the form of galvanisation of the head, and general faradisation, as worthy of note in refractory cases.

Having endeavoured in these observations to portray the scope of Professor Bianchi's recent contribution to psychiatric literature, it remains for us to pay a tribute to the intrinsic merit of the work.

The Growth of the Brain. By H. H. DONALDSON, Prof. of Neurology, Univ. of Chicago. W. Scott : Lond., 1895. 8vo, pp. 374. Contemporary Science Series.

This work is a very useful compendium of the facts relating to the growth of the brain, with concluding chapters on fatigue, old age, and education. The work is illustrated by upwards of seventy plates and by nearly as many tables, the majority of both being authorised reproductions from standard authors to whom the author has universally given quotation.

Commencing with an introductory chapter on growth in its widest aspects, he passes on to the facts relating to the increase in weight of the whole body, followed by a chapter on the weight increase of different parts of the body and on increase of stature. The weight of the brain and spinal cord is next dealt with, increase of brain weight, the variations of brain weight and of cranial capacity each occupying a chapter.

The nerve elements, their development and arrangement are next considered, together with the architecture of the nervous system and the changes in it due to growth.

Localisation of function, physiological changes in the central system, physiological rhythms, and old age, are each treated of in separate chapters.

The facts thus compiled being already well known, offer no room for criticism, but the author may be congratulated on the very systematic manner in which they have been arranged, on the clearness and conciseness with which they have been stated, and on the general suggestiveness that pervades the book. He has been careful, too, to point out, in many places, defects of observation, and gaps in our information that require to be filled up.

The mass of facts and information relating to the brain thus brought together, constitute the work a very handy book of reference, not only to the parent, teacher, and physician, to whom the author considers his work specially directed, but also to the medico-psychologist.

PART III.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

GENERAL MEETING.

A General Meeting of the Association was held on May 21st, at 11, Chandos Street, London, David Nicolson, M.D., President, in the chair.

The minutes of the last meeting (held at Cambridge) were read by Dr. Fletcher Beach, Honorary General Secretary, and confirmed.

DISCUSSION ON PSEUDO-GENERAL PARALYSIS.

Dr. Hyslop's paper, read at the last meeting, was discussed at Cambridge as follows:—

Dr. SAVAGE—When the question of pseudo-general paralysis appeared upon the paper, at once one had to define what one understood by pseudo-general paralysis. My first thought, and perhaps the thought that still remains with me, was this: Cases of pseudo-general paralysis are those where I had made a mistake in diagnosis—cases where I dogmatically said a patient would die in two or three years, and they are still living after many years. There are many such cases, and the more we see of the earlier stages the more difficulty we find in coming to a correct diagnosis. Next as to the question of pseudo-paralysis described by the French. They have got pseudo-paralysis and pseudo diseases of one kind and another, and I think with Dr. Hyslop it would be a very good thing if we could limit the true and get rid of the false. General paralysis of the insane I believe to be a degeneration. I think there are certain types which we must recognise. My favourite teaching simile is that, looking at general paralysis of the insane as a degeneration, one has to remember that the evolution, the development of things, depends upon the environment as well as the starting point. One is obliged to recognise that each bodily organ has its own method. In old days everybody who died by lung diseases and had a cough, therefore had phthisis. We know now there are many other forms of such degeneration. So one feels in regard to degeneration of the insane so-called, we have other forms of degeneration which we shall in future separate, and it is well papers so ably brought forward as that by Dr. Hyslop should be considered by us. I do not say the term general paralysis is of a satisfactory kind. Still it is a term that we understand and can employ until we get a better one. We say they are suffering from softening of the brain, meaning hardening; we say they are suffering from brain paralysis when we are talking to lawyers, because they understand that;

and if we are talking to one another we call it G.P.I. We do recognise it is not an entity; it is a group of symptoms. But we cannot do without the term at present.

Dr WIGLESWORTH—I think Dr Hyslop has brought an important subject before us to-night, because we know many cases are put down for general paralysis, but which recover, and which prove eventually not to be such. Some alcoholics, for instance, present in practice most puzzling cases to diagnose, and I was in hopes Dr. Hyslop would have furnished us with some diagnostic marks which would assist us in coming to a conclusion in such cases. I am afraid so far we have not had much assistance in this respect. We should recognise the fact that there are cases which put on an appearance of general paralysis, and which eventually turn out not to be such. But I wish to run counter to one general opinion in the matter, and that is that true general paralysis can never be cured. The opinion seems to be, if a case presents certain features, goes into an asylum, is diagnosed as general paralysis and gets better, that case is not general paralysis. I don't agree with that. I have seen cases come into an asylum and become practically well, that is to say all signs of general paralysis have disappeared, but the patient has not been perfectly well. I am not referring only to cases which have gone out, but also to cases which one hardly felt justified in discharging. I have known cases in which you could hardly feel justified in discharging the patient, though there has been the slightest amount of dementia and there has been an entire absence of all signs of general paralysis. I have known cases to die in the asylum even as long as 20 years afterwards, which have pathologically shown limited signs of general paralysis, and I have known other cases which have gone out and which have remained well certainly for years. I consider such cases are practically recoveries. Therefore, when we make the sweeping assertion that because a case gets well, therefore it is not general paralysis, I don't think that helps us at all. There is another point in which I should rather join issue with Dr. Hyslop. He referred to cases occurring in children about the time of puberty, which present certain signs of general paralysis, and he said he could not see why they should be classified as such; they should be called syphilitic cases. I should like to know why. Why are they not to be considered general paralysis? Is it because of the age? Clearly that would not be scientific reasoning. I refer to cases I have observed, and where after death the lesions of general paralysis have been found. How are we to resist the conclusion that they should not be so classified? Dr. Hyslop apparently does not consider them syphilitic diseases. I must say, whatever name we give it, general paralysis is a disease we ought to include in our neurology. To every name some exception may be taken and "general paralysis" will perhaps serve as well as any other.

Dr. SHUTTLEWORTH—Mr. President, there is just one point to which the previous speaker, Dr. Wiglesworth, has alluded, of which I have had some experience which may be interesting, and that is cases of inherited syphilis occurring amongst children. I am afraid I am not competent to say what are and what are not the pathological appearances of general paralysis; it seems to me to cover a great number of symptoms, and perhaps the pathological appearances may vary to a considerable extent; but having seen some cases of post-mortem of children who suffered from juvenile syphilitic dementia, one met in two or three cases with similar symptoms in which there was considerable thickness of the cerebral membranes and considerable atrophy of the brain substance. The cases varied very considerably in the time during which the symptoms were evolving. They occurred usually at the age of 12, 13, and 14, and so on, in children who up to that period had shown a certain amount of mental power; then came a period of mental enfeeblement, during which they lost all the knowledge they obtained at school; and finally they lost not only mental power, but displayed some degree of paralysis. Some of these cases which I left behind me at the Royal Albert Asylum, had certainly been in that state, without any great progression, for 7 or 8 years. I don't know whether they are dead, but what I want to lay stress on is that in every case one was able sooner or later to work out a psychological history.

The adjournment of the debate to the next meeting was proposed by Dr. HAYES NEWINGTON and seconded by Dr. RAYNER.

The PRESIDENT, on rising to put the resolution, said—There is no doubt, whether pseudo-general paralysis is an entity or not, it is quite evident it is a very considerable quantity, and an unknown one apparently, and a subject for discussion, sometimes not very fruitful, but always encouraging to investigators. I am bound to say I do not quite like Dr. Savage's swamping it under the term of "degeneration." That term "degeneration" seems to be so unhelpful to us in arriving at any notion of the pathological condition that may be discoverable after death, or the symptoms which may be exhibited during the extended period when the patient is resisting the programme of carrying out his demise within the period allotted to him by the consulting medical officer. I have always regarded general paralysis of the insane in all its collateral development as the very hotch-potch of nervous pathology, but I am quite willing to put the resolution, that Dr. Hyslop's paper be discussed by adjournment at the meeting to be held in London in May.

The resolution was carried.

In answer to the discussion, Dr. HYSLOP said—I think the only point, if there was any point in the discussion, was the objection taken by Dr. Wigglesworth, in which he said it was not exactly warrantable to consider a case as not a case of general paralysis because it recovered. I employ the term "general paralysis" in contradistinction to special paralysis. I think I distinctly laid it down, and the only exemplification I know of of true general paralysis is the condition of dissolution immediately preceding death. I don't understand the term "general." The cases that recover or go on for a lengthened period, go on with special paralysis. It is not, truly speaking, general paralysis. Anything that does not favour this rule of "general" I consider to be more or less special, and so long as they are included under the term "general" they are pseudo general.

The discussion was re-opened, on 21st May, by Dr. HAYES NEWINGTON.

Dr. HAYES NEWINGTON—Mr. President, I do not suppose that any of us—even Dr. Hyslop himself—will expect any practical good to arise from the discussion on this subject, which he so ably introduced; but I think we may all expect some indirect benefit to be obtained by recording the large amount of dissatisfaction and unrest with which our present relations to so-called "general paralysis" are mixed up. I do not refer to the scientific or the pathological aspect of the matter, because on every important point of this nature there must always be unrest until we reach the end—which is not likely to be; but with regard to the social or prognostic side I do think that most of us feel highly dissatisfied. We rather shirk accepting the proposition that general paralysis is progressive and fatal. We think—at least I do—that where we get such a terribly definite predicate as fatality and the almost as terrible predicate of progressiveness, the subject should be equally definite; and it does seem to a good number of us to be rather a strong thing to accept as final the verdict on such a very unsatisfactory basis. Dr. Hyslop has put before us all the forms that imitate general paralysis. Dr. Wigglesworth took other ground, if I remember rightly, and said that all these forms were general paralysis, but some of them were recovered from. I should like to ask on what grounds we can positively assert that all general paralytics must be insane. All we go upon is experience. We take the question of prognosis from experience; and I think it is hardly right to use experience as a means or a method or a tool with which to cut off the possibility of further experience. Because we have not yet found that general paralysis is usually curable it does not follow that it may not be so in time, for surely the type is altering and spreading. In the old days it was tolerably definable and restricted within certain limits; now it is spreading, not only with regard to its symptoms but also with regard to the people it attacks. It is spreading as to the class of people and especially the age of the victims; it is spreading up and it is spreading down. On these grounds alone I think we ought to be careful before we lay down such a

terrible proposition as that general paralysis is invariably and necessarily fatal. I am the rather encouraged to take that ground because in studying Dr. Clouston's definition of this disease I see that he winds up with the words "*as yet incurable*," as much as to say that there is a possibility of cure. We all trust there may be.

Dr. GOODALL—With regard to the first question that Dr. Hyslop puts to us, whether the term "general paralysis" is entirely satisfactory, I am not myself disposed to think it is: and I should prefer the term of "progressive paralytic dementia," as bringing us more into accord with the terms used on the continent, and also, I think, expressing more faithfully the nature of the disease. I think that at present general paralysis or progressive paralytic dementia must be regarded fairly as a disease like Bright's disease, a term used collectively just as that term is used. Under that term, as is well known to us all, there are several varieties of morbid kidney described—cystic diseases of the kidney, granular disease and congestive conditions, large white kidney and so forth. So under the term "general paralysis" I think there are various forms included at present which later may be differentiated. In the earlier stages of Bright's disease, no doubt, there is considerable difficulty in describing the various symptoms, localising them, and referring them to particular disorders or states of the kidney. Gradually that has been done, so that in respect of etiology, clinical symptoms, pathology and morbid anatomy, the study of Bright's disease is fairly satisfactory. The same could not be said about general paralysis in all these respects. More work, I think, should be done so as to make the knowledge of the subject more exact. On page 304 of the Journal Dr. Hyslop quotes a statement that "general paralysis is as distinct from any other disease as small-pox is from scarlatina." I do not agree with that. It may be distinguishable, but not quite so easily. The clinical types in general paralysis are naturally a good deal more difficult than in Bright's disease, seeing that the brain is so highly complex. Various parts may be affected, so that the different types of general paralysis may be numerous and complicated. It may be that some of the acute types run a rapid course, and also that some phases of the disease, such, for instance, as extravasation of blood in the brain, and possibly also epileptiform convulsions, may be due to the action of micro-organisms, which might possibly differentiate a particular form of the disease. But in order to help us to get a more exact knowledge of the pathological processes obviously it is highly necessary that post-mortem examinations in early cases should be obtained. Unfortunately in large County Asylums death occurs at an advanced stage when everything is almost at dissolution. I think, however, that in certain County Asylums differentiation is not a matter of such great difficulty as it is in hospitals like Bethlem, because in several asylums, especially those in the West Riding of Yorkshire, the type seems to be becoming dementia, rapid degradation, running down to paralysis of mind and body. As a matter of fact the prognosis is pretty easy, and differentiation of the disorder is pretty easy; whereas, I fancy, in a more highly educated person the differentiation and prognosis would be a matter of more difficulty. Lately I have been studying a work by Prof. Bianchi. He is very jealous of this term "pseudo-paralysis," chiefly, I think, because he is inclined to believe that new diseases have been foisted upon it. Dr. Hyslop was careful to say he had no intention of introducing a new disease. I think Prof. Bianchi would have to admit that, since in his work he discusses disorders which simulate general paralysis. Incidentally, in conclusion, I would say that Prof. Bianchi is not inclined to attach so much importance to syphilis as a cause as many writers do. He considers that syphilis may only act, like so many other factors, on constitutions predisposed to the disorder, and I am disposed to agree with him.

Dr. BONVILLE FOX—I cannot but think that Dr. Hyslop sets up too exhaustive a series of requirements for the disease he styles general paralysis. Is it a disease in which disorders of motility must sooner or later affect the system generally; or is it a disease in which disorders of motility may very possibly affect the system generally? In all probability, if the patient lives long enough they will, but I believe it is by no means necessarily the case that they must. Four years ago there was a case of general paralysis under my care with slight

tremor of the lips, a little lingering articulation, but no other disorders of motility. So slight, indeed, were the symptoms that a Commissioner, whose opinion as a scientific man we all respect, doubted very greatly whether the diagnosis was correct. Three years ago a case was under my care of a man who was stretched out helpless, unable to move arms or legs, unable to defæcate, unable to relieve his bladder, unable even to swallow when his pharynx was irritated. This very morning I saw a man with very marked defect of articulation, so much so that you could hardly understand him, but able to walk for a couple of hours in such a way that I will undertake to say it would try the powers of most of those present to keep up with him. Which of these cases was general paralysis? Or were not all of them general paralysis? I believe they were, for they all occurred in the same man. I have spoken of the same patient at different periods, and I have instanced his symptoms in the order in which they occurred. The helpless log of three years ago surely exhibited general paralysis if ever a man did, for the only centres that, so far as I could see, were not paralysed were those of his respiration and of heart; everything else nearly was paralysed. I admit that there are still many symptoms of general paralysis. But are we to deny to the man now in his later condition the name that we should all have accorded to him three years ago? Surely not. We do not in other diseases expect to get the whole repertory of classical, typical, pathognomonic phenomena in each particular case. (I do not in the least wish to misconstrue Dr. Hyslop's definition.) For example, if in a case of pneumonia we do not get herpes labialis, we do not in the least deny that it is pneumonia, because that one symptom, which is sometimes present, is absent. I am, therefore, inclined to think we should be wide in our definition of general paralysis of the insane. I do not for a moment assert that it is a scientific term; but I believe it is a convenient term which has passed into general acceptance, and which most of us recognise as meaning a certain class of disease. If I may for a moment criticise Dr. Hyslop's term of "pseudo-general paralysis," I would say that it seems to me we do not gain very much by adopting it. I fully agree with him that there are many mental diseases which most closely simulate general paralysis—and he has described them very accurately—such as alcoholic pseudo-general paralysis, saturnine pseudo-general paralysis, and one or two others. But why should we call it alcoholic *pseudo-general* paralysis, etc.? It seems to me the description would be equally clear and certainly scientifically more accurate if we were to drop the "pseudo" altogether out of the definition and speak of the symptoms as those of alcoholic paralysis. I admit it is impossible in some cases to tell whether a patient is suffering from alcoholic paralysis or general paralysis. But time, which is the great elucidator as well as the great consoler, will clear up the matter if the case is one which will allow of an accurate diagnosis; and I fail to see what we gain by christening cases that resemble general paralysis, but are not cases of that affection, by such a term as alcoholic pseudo-general paralysis instead of simply using the designation alcoholic paralysis. At the same time I am far from desiring to express myself dogmatically. I fully admit that there are various considerations which complicate our definition of the disease and which greatly complicate our prognosis of the disease. For example, we all recognise that general paralysis may be coincident with tabes and with peripheral neuritis; but I think it is altogether unfair to say that a man who has had tabes and been suffering also from paralysis is the victim of general paralysis of the insane all the time he has spinal symptoms. That the one disease should merge into the other is, I am bound to say, hardly extraordinary when we consider how closely the different parts of the nervous system are connected. It is always to me rather a wonder that we get the symptoms of different nervous diseases so clearly defined and distinct as we do.

Dr. SOUTAR—Dr. Hyslop, of course, must have been prepared for criticism, as he has struck out new ground, and I, too, must join with Dr. Fox in a criticism of Dr. Hyslop's attack upon the term "general paralysis." It seems to me that he has raised an altogether unnecessary difficulty. He seems to think that the term "general" is synonymous with "complete," for he argues that general paralysis exists only in the stage immediately

preceding death. But I think that in so doing he gives an altogether unusual meaning to the word. The term "*general paralysis*" does not convey, and is not meant to convey, any indication of the *degree* of paralysis, it is simply a convenient term for indicating the fact that we have to deal with a paralysis not only of the body but of the mind as well, a paralysis which is general, that is to say, in that sense, that you have an implication both of body and mind, and in no other sense is it used in the general acceptance of the term. I, therefore, think that "*general paralysis*" happily indicates the consideration, and is certainly quite as useful as the one suggested by Dr. Hyslop. We have then in the word "*general*" simply an indication of the dual implication of both body and mind; that is, general paralysis is a form of enfeeblement in which both the mental and physical functions are affected. Of course this view does not necessarily strike at Dr. Hyslop's main contention, namely, that we probably include in the term "*general paralysis*" several diseases which differ from one another in certain features; and, of course, it is an extremely laudable task to attempt to distinguish these diseases one from the other. It seems to me, however, that the principal value of Dr. Hyslop's paper in this connection is that he has demonstrated that, even under his very competent guidance, we have not proceeded very far in effecting a differentiation such as he desires. He gives examples of what he calls "*pseudo-general paralysis*," that is to say, of cases which simulate general paralysis, but which in his opinion are not cases of general paralysis. But what do these cases show? They simply show this, that alcohol, lead, syphilis, fever, malaria, and sunstroke induce, in a certain number of cases, a degradation of the nervous system which is undoubtedly general in the sense that you have both body and mind affected. But Dr. Hyslop goes on to say that the point of distinction between these "*pseudo*" cases and the true cases of general paralysis is that you have in one set the disease arrested, whereas in the other it proceeds to death. But the first point that has to be established in a contention of that kind is this, that it is impossible to have an arrest of true general paralysis; and I do not think Dr. Hyslop establishes that contention. I think he fails to show that there is any necessity for calling these cases "*pseudo-general paralytics*," for it is quite clear that if an arrest can take place, and does take place, those cases of "*pseudo-general paralysis*" are simply cases of general paralysis in which the disease has been arrested. I am, of course, aware that in some of the definitions of the disease which we have it is dogmatically laid down that the end of the disease is death in a comparatively short time. But then Dr. Hyslop is certainly outside the protective pale of these definitions, because we have in his paper something absolutely or almost entirely of the nature of a revolt against these accepted definitions. I think the question he has really raised is not whether these cases are cases of general paralysis, because unless the word is unduly perverted the cases are those of general paralysis; but the question is, Do we ever find arrest in a true case of general paralysis? Undoubtedly we find that in a good many cases of true general paralysis, cases which run the true and orthodox course, certainly alcohol and syphilis and malaria, and more doubtfully sunstroke, are the only ascertainable causes of the disease. So if in a certain set of cases we find that some causes induce true general paralysis, and in another set of cases we have induced these "*pseudo-general paralyzes*," we must have great difficulty, I think, in accepting Dr. Hyslop's conclusion until he has demonstrated that there never is an arrest of general paralysis in the true sense. My opinion, then, is that we had better stick to "*general paralysis*" as a well understandable term, one that includes a group of diseases in which we have enfeeblement both of body and mind, and is therefore general; but that perhaps—and I think Dr. Hyslop's paper strongly suggests this—we must be prepared, to some extent at all events, to modify our idea that general paralysis is inevitably a disease that proceeds to complete and absolute dementia and paralysis.

Dr. MERCIER—Dr. Soutar is correct when he states that Dr. Hyslop uses the word "*general*" in connection with general paralysis in a misapprehension for "*complete*." By a general paralysis Dr. Hyslop means a complete paralysis. I think there are very few of us who agree with him in accepting that meaning of

the term. Dr. Soutar, however, uses "general" to mean "dual," which seems to me a still greater departure from the original sense of the word than Dr. Hyslop's. I have always understood "general paralysis" to mean a paralysis that was not necessarily complete, that certainly was not necessarily dual, but that was general, that is to say, a paralysis which affects more or less the whole voluntary muscular system of the body, and which follows, of course, the classical course in affecting first and most those portions of the muscular system which have the most definite centres; while those that are least and last affected are those which are the most general. That is what I understand by "general paralysis." As for a paralysis affecting the mind, that is a metaphysical notion, coming from a north country channel which I would be very sorry to attempt to criticise.

Dr. ANDRIEZEN—I think we are indebted to the French school of observers more particularly for clearing away some of the misconceptions as regards certain of the superficial symptoms of general paralysis, and especially to Magnan. He lays very great stress indeed upon what he calls the fundamental and the episodic characteristics or symptoms of general paralysis. The fundamental characteristics run through every case of the disease, whatever the clinical type. The case may at one time show symptoms of melancholia, at another of mania, and at other times may be suffering from a more gross form of subacute delirium with loss of flesh, slight febrile temperature, offensive breath and dirty tongue; and I have no doubt in connection with such cases the investigation of the urine, the intestinal canal, etc., should be followed out to ascertain if some micro-organism is at work. Experience of other diseases teaches us that they may from time to time show symptoms of various kinds; but that does not prevent us calling a case of phthisis by that name, because, after running a certain course with certain symptoms, it may towards the termination be complicated with other conditions and have other organisms in the lungs than the specific bacillus. With regard to general paralysis, the fundamental features are the gradual and progressive deterioration of the mental faculties, side by side with which is more or less of a corresponding degradation of the movement functions of the body. One recognises that both these functions are localised in the brain in more or less adjacent and overlapping areas. One need not therefore be surprised that this should be the case. And further, when one notices that the term "chronic diffuse parencephalitis" has been used, especially by German observers, instead of "general paralysis," and when one finds that in every case where a post-mortem has been made there are distinct evidences invariably of more or less diffuse chronic parencephalitis, one cannot help admitting that there is a disease which runs a very definite course fundamentally, the main features of which I have described. All other conditions should, I think, be considered as Magnan calls them, episodic symptoms, because they need not necessarily occur. In certain types of general paralysis it is only the fundamental symptoms that are observed; the mania, melancholia, hallucinations need not be present. So, too, with congestive conditions and the discharges from the lower centres which produce epileptiform convulsions. With regard to the term "pseudo-paresis," it is a convenient one for purposes of speech; language is not so rich that we can afford to dispense with it. But one cannot say that the somewhat heterogeneous group of conditions included under that term deserves distinction into a separate group; whereas general paralysis has a very characteristic physiognomy, clinical, etiological, and pathological, of its own. Therefore I think it would be a mistake, and rather late, considering what has been done, for observers to attempt to upset the theory of the clinical and pathological entity of general paralysis of the insane.

Dr. BLANDFORD—I had not the pleasure of hearing this paper read at Cambridge, but I have read it since. I do not look upon it as indicating any wish on Dr. Hyslop's part to set up a new nomenclature and call syphilitic insanity or alcoholic insanity a pseudo-general paralysis; but I look upon it as a protest against calling everything general paralysis, from the disease which attacks a boy of twelve up to that which attacks a person of seventy. It appeared to me Dr.

Hyslop's intention was to protest against that and to mention certain forms which simulate general paralysis, but which are not general paralyzes in the ordinary sense of the word. And I think it extremely important we should do this. Dr. Blandford then dwelt on the necessity for correct diagnosis, and added: I am bound to say that the longer I live the greater difficulty do I find in doing so in these cases. Thirty years ago I thought there was no difficulty in diagnosing general paralysis, but I find a very great deal of difficulty now. Of course, merely looking at the patient perhaps for a quarter of an hour or so is not sufficient. It is very important we should get at the history of the case, and approach it from all sides. It is very important we should arrive, if we can, at an accurate diagnosis, because a great deal sometimes depends upon the diagnosis and the opinion we give whether we are quite sure that it is a case of brain degeneration from which the patient will not recover. It is very important for the sake of the friends that we should be able to tell them how long the patient is going to live, and whether he is likely to be violent or go off in acute mania, which we so often find in general paralysis, or whether it will be a gradual degeneration and decay so that he may be taken care of anywhere with proper assistance. Now, when we come across a case of alcoholic insanity, for instance, we may go extremely wrong if we call that a case of ordinary general paralysis. Dr. Blandford quoted a case of alcoholic insanity, brought to him as general paralysis, which had deceived some of the best observers in the specially, and added: I merely mention this to show the difficulty of diagnosing these cases and to show the importance of arriving at a correct diagnosis. The doctors in this instance were kept in the dark with regard to that, and only based their opinion on the patient's condition as they saw him before them.

Dr. HYSLOP—Many observers assume that if there is one thing certain in our specialty, it is that general paralysis is an entity and a disease described as such. On questioning such observers one finds there are but slender arguments in favour of this notion. The main thing is, it is a question of convenience. It is a very convenient term. I look upon it as being absolutely a dustbin for the reception of all they cannot understand. The question as to what general paralysis really is has been discussed, and nobody present has answered the question. Dr. Soutar says he understands by the term an affection of the body and of the mind. If that is the meaning of "general paralysis" then I must own that every mental affection we know is general paralysis, because I know of no mental affection in connection with which we do not assume there is a bodily affection. Dr. Mercier says my notion of "general" is too wide (Dr. Mercier: "No, No"). I understand Dr. Mercier has a special idea of his own as to what is meant by "general."

Dr. MERCIER—No. I merely said "general" meant "general."

Dr. HYSLOP—Then I would ask some definition of "general." You may assume that "general" is to be taken in the Jacksonian sense, and one has nothing to say against that theoretically, but in that case how are we to distinguish such conditions as amyotrophic lateral sclerosis, progressive bulbar paralysis, etc., associated with mental symptoms, if we hold the entity notion of general paralysis. There has been no argument given so far in favour of that condition being general. I do not think anyone here has seen a case which is truly general. I know of no spinal lesion, except a diffuse myelitis, and have never seen one in which all the tracts have been affected, in which one could say definitely the paralysis was general. Therefore on these grounds I certainly do quarrel with the term. To some people's minds it has been quite sufficient to establish the entity of the condition to discuss the halo around that condition of mental exaltation, but you may get the same halo in anyone suffering from any mental paralysis that you sometimes get in so-called cases of general paralysis. A progressive paralysis treated in a general hospital is treated as such and regarded as a special paralysis, but directly mental symptoms supervene, the patient loses control or shows a certain amount of general exaltation; at once he is removed from the general hospital and relegated to the alienist dustbin as a case of general paralysis, a condition which is regarded definitely as an entity. I quite agree that it is a very convenient method; but when we class such patients as general paralytics we argue from our

knowledge of a large number of cases that the patient will probably die in the course of two or three years, and apply that general knowledge, derived from various sources, to the special case in hand which may be totally different. For a good many years I have been looking for a case that I could honestly regard as being one of general paralysis, and in not one case have I been able to satisfy myself that I have seen symptoms during life that would indicate general paralysis. I have seen indications of various progressive lesions, ascending lesions, descending lesions, and lesions beginning in various parts of the cerebro-spinal system, but I have not come across a case that I could definitely regard as being one of true general paralysis. I have seen cases of death, and that, as I pointed out, has been the only indication. As to the question of this being a collective term, Dr. Goodall pointed out that we classed under the general term "Bright's disease" various conditions of the kidney, with which I quite agree; but so long as we regard these different varieties as one disease and call them Bright's disease we do not gain much. We may well understand in what a glorious state of uncertainty would be the physician of a general fever hospital who made a hotch-potch of such different conditions as typhoid fever, small-pox and measles, as we do now in the case of general paralysis, and treated them by the application indiscriminately of his general principles. That is precisely the state we are in now with regard to general paralysis. We are not able to give a prognosis simply because we do not study and differentiate the different conditions of which this so-called entity is made up. I think Dr. Blandford was the only speaker who gave me credit for not wishing to describe by that name any case which might be called pseudo-general paralysis. I merely wish to point out that there are various toxæmias and paralyses which appear to be like general paralysis, but are not examples of that condition; and if we followed out that plan of calling the different cases what they are, dropping the "pseudo," it would be more scientific. It would be very interesting indeed to study all these cases and eliminate all the special forms of the disease and see what we have left of general paralysis by the time we had done so with syphilitic, alcoholic, and the other paralyses referred to. There might be a trace of the so-called entity, but, I fancy, not a very substantial trace. I am afraid therefore that as yet arguments given in favour of the entity theory, and the arguments adduced against my paper, do not carry conviction to my mind. What they do with others, of course one cannot decide. I have been several times asked since I read my paper what good can possibly accrue from destroying faith in this convenient disease about which we have general principles to guide us in dealing with the friends of patients. What, I have been asked, are you going to put in its place, and what are you going to call the disease? I do not propose to substitute any other term for so-called "general paralysis." What we have to do is to define its numerous contents and then name these contents accordingly; and when we have done that I think there will be absolutely no use for any such expression as "general paralysis."

The PRESIDENT—I am sure, if the question were put, of what use has Dr. Hyslop's paper been? we have had abundant evidence this afternoon that it has stimulated thought and encouraged philological discussion as to the meaning of terms and their origin, and many of us at any rate will not be any the worse, on the contrary most of us will be much the better for having heard the learned points raised, if not solved, by Dr. Hyslop's paper.

Dr. ROBERT JONES then read "A short account of Claybury Asylum (the first new Asylum of the London County Council) and the history of its first year."

Dr. RAYNER—Our thanks are due to Dr. Jones for giving us such a careful history of the growth and development of Claybury Asylum. To hear of such perfection in all its arrangements makes those of us who perhaps have served in rather old buildings envious of Dr. Jones for having such a splendid place. Those of us who have had to deal with large numbers of patients must congratulate him on having been able to conduct the admission of two thousand patients without meeting with any serious mishap or any regrettable incident.

A paper by Dr. MERCIER on "Medical Reticence" was to have been read at

the meeting; but on the suggestion of the Honorary General Secretary, Dr. Mercier consented to its being postponed till the Annual Meeting.

The following gentlemen were elected members of the Association :—George Beamish, L.R.C.S.I., L.R.C.P.E., L.M., Medical Officer, H.M. Prison, Liverpool ; John W. Geddes, M.B. and C.M.Edin., Assistant Medical Officer, Durham County Asylum, Winterton, Ferryhill, Durham ; Robert Wilson, M.B., C.M.Glas., Nailsworth, Gloucestershire.

SPRING MEETING OF THE SCOTTISH DIVISION.

A meeting of the Scottish Division was held in the Hall of the Faculty of Physicians and Surgeons, St. Vincent Street, Glasgow, on Thursday, 12th March, 1896.

Present—Dr. Carswell (Glasgow), Dr. Margaret C. Dewar (Dumfries), Dr. Edgerley (Melrose), Dr. Havelock (Montrose), Dr. Hotchkis (Glasgow), Dr. MacDowall (Morpeth), Dr. Macpherson (Larbert), Dr. Oswald (Glasgow), Dr. Alexander Robertson (Glasgow), Dr. G. M. Robertson (Murthly), Dr. Turnbull (Hon. Sec.), Dr. Urquhart (Perth), Dr. W. R. Watson (Govan), and Dr. Yellowlees (Glasgow).

On the motion of Dr. YELLOWLEES, Dr. MacDowall was called upon to preside.

The minutes of the last meeting were read and approved.

The Secretary submitted applications for admission as members from Hamilton C. Marr, M.D., Senior Assistant Physician, Woodilee Asylum, Lenzie, and William Cardiff Hossack, M.B., C.M., Assistant Physician, District Asylum, Inverness. On being balloted for these gentlemen were unanimously elected members of the Association.

MEMBER OF COUNCIL AND DIVISIONAL SECRETARYSHIP.

On the motion of Dr. YELLOWLEES it was agreed that the name of Dr. Watson (Govan) be suggested to the Council for election when filling up the next vacancies on the Council ; and that of Dr. Turnbull (Cupar-Fife) for the Divisional Secretaryship.

PENSIONS SCHEME.

Dr. URQUHART submitted a report, prepared by Mr. J. A. Robertson, C.A., Edinburgh, for the Pensions Committee, and suggested that a copy should be sent to the Council by the Divisional Secretary, with the request that the matter should be placed on the agenda paper of the next Annual Meeting, as having the approval of the Scottish Division.

After some conversation this was agreed to, and on the suggestion of Dr. TURNBULL it was resolved that Mr. Robertson's report should be printed, and a copy sent to each member of the Scottish Division.

CARLISLE MEETING.

Dr. TURNBULL, for Dr. Carlyle Johnstone, intimated the arrangements for the Annual Meeting of the British Medical Association at Carlisle, and hoped that there would be a good attendance from Scotland.

FORMS FOR CASE TAKING AND FOR OTHER ASYLUM RECORDS.

Dr. URQUHART submitted forms which he had prepared for case taking in the admission room and in the wards—a scheme for case books and a card index to cases. He also laid on the table various charts and lithographs procurable from Messrs. Daniellson ; and a chart for recording mental states devised by Dr. Watson, of the Winson Green Asylum, Birmingham.

COLLECTIVE INVESTIGATION COMMITTEE.

Dr. G. M. ROBERTSON submitted the proposal by the Collective Investigation Committee that "Statistics and Types of Epileptic Insanity" be the subject adopted for examination, and said one of the recommendations agreed to at the last meeting of this Division was that the suggestions of the Collective Investigation Committee should be printed on our agenda paper. The reason of the

present suggestion is that at the last Annual Meeting of the British Medical Association Dr. Gower asked that such facts should be collected. If the Division is willing that this investigation should be made, forms might be drawn out relating to the subject. The statistics can be got to a large extent from the Annual Reports of our asylums, probably all the statistics that are required as to the forms of insanity that epileptics labour under, and also facts relating to dementia and fits, and as to whether insanity replaces fits, and at what period the patients suffer from acute symptoms as indicated by Dr. Gower.

The CHAIRMAN—I hope the Committee will not go to Annual Reports for information on anything.

Dr. YELLOWLEES—Epileptic insanity is a very vague expression. We know that there are people who take fits every six or eight weeks and labour under a greater or less degree of mental weakness; but there are others who have fits, one in a year or in two or three years, and you may not know that a patient ever had them. Are these cases of epileptic insanity?

The CHAIRMAN—I think not.

Dr. YELLOWLEES—They are far more frequent than we are apt to suppose.

The CHAIRMAN—Would you wish this suggestion sent up to the Council?

Dr. TURNBULL—It was intended that the gentleman who proposes a subject for investigation should act as secretary; and if Dr. Robertson would be willing to issue the questions to the members of our Division it would ensure the present proposal being carried through.

The CHAIRMAN—You will be glad to do that, Dr. Robertson?

Dr. ROBERTSON—Yes, certainly.

After some conversation Dr. Robertson's proposal was adopted.

On the motion of Dr. YELLOWLEES a hearty vote of thanks was given to Dr. MacDowall for presiding. The members afterwards dined together in the Windsor Hotel.

MEETING OF THE IRISH DIVISION.

A Meeting of the Irish Division was held at the Richmond Asylum, Dublin, on May 7th, 1896. There were present Dr. Hetherington (Londonderry), in the chair, Dr. Garner (Clonmel), Dr. O'Neill (Limerick), Drs. Finnegan and Elizabeth Moffett (Mullingar), Drs. Patton and Dawson (Finglas), Drs. Eustace and Henry Eustace (Glasnevin), Drs. Conolly Norman, O'C. Donelan, H. C. C. Cullinan, D. F. Rambaut, E. L. Fleury, Dr. Burke (Dublin), and Dr. Oscar Woods (Cork), Hon. Sec.

The following gentleman having been proposed for membership, was balloted for and unanimously elected:—Thos. Adrian Greene, L. & L.M.R.C.S.I.; L. and L.M.R.C.P.I., Assistant Medical Officer, District Asylum, Ennis.

MORNING MEETING.

Dr. CONOLLY NORMAN said before the first subject on their agenda paper was discussed he wished to ask whether the meeting was prepared to listen to a brief statement from him in regard to the question of a Trades Union being formed called "The National Trades Union of Asylum Attendants in Ireland," and to the report that appeared in the daily papers that morning? They could consider it as a matter of urgency.

The CHAIRMAN said they could take the matter up under their first Rule.

Drs. FINEGAN and GARNER agreed as to the importance of discussing this subject together with the training of attendants.

Dr. NORMAN then said they would find in a newspaper called the *Irish Times* of that date a report of the regular meeting of the Board of Governors of the Richmond District Asylum, held yesterday. That newspaper report contained the following sentences:—

"A report was read from a Committee of the whole Board, in relation to the rules of the National Union of Asylum Attendants of Ireland, a copy of which

had been forwarded to the Board. The Committee resolved that the Board of Governors be requested to decline to recognise this society, and to inform their attendants that to become a member of it will be held to disqualify them from employment in the Institution.

“The following resolution was now adopted :—

“That we adopt the report of the Committee, the Medical Superintendent to see the men whose names are attached to the rules of the Society called “Asylum Attendants of Ireland Trades Union,” and communicate to them the decision of the Board, and that they are dismissed from service in the asylum unless they at once withdraw from the Society.”

Dr. Norman said he thought he was justified in quoting to the Association the published rules of the Society or Trades Union referred to. He quoted from a printed copy such as were on sale. The persons who had framed this curious document seemed to think a combination of attendants had the power of taking from the Governors of Asylums the right of managing the institutions which was committed to them by Act of Parliament. The first of the Union rules runs as follows:—“The Society shall be called the Asylum Attendants of Ireland Trade Union. The object of the Society shall be to improve the condition and protect the interests of its members; to endeavour to obtain and maintain reasonable hours of duty and fair rates of wages; to promote a good understanding between employers and employed, the regulation of their relations, and the settlement of disputes between them by arbitration, or failing arbitration by other legitimate means; to provide temporary assistance to members when out of employment through causes over which they have no control, or in resisting unjust treatment; to provide legal assistance whenever and wherever necessary in matters pertaining to the employment of members, or for securing compensation for members who suffer injury by accidents in their employment occasioned by the negligence of their employer, or for those for whom their employer is liable; also to provide a grant of money in case of members permanently disabled.” Continuing, Dr. Norman said these rules which he had laid before them simply expressed a determination to endeavour to specially create, in this particular case of attendants, a Trades Union, the principal end of which, as of all such organisations, was the perfecting of the ordinary Trades Union weapon—the weapon of strike. He did not anticipate any danger so far as his own asylum was concerned. In the Richmond Asylum the decisive and prompt action of the Board had, as they would gather from the newspaper report, put a stop to this business, but it might possibly break out in other asylums, and may under other circumstances, and in the hands of a Board less firm and determined, give a good deal of trouble. It occurred to him that this was a matter which, considering the fact that the attendants of Irish Asylums are virtually civil servants, are persons appointed and dismissed under the regulations of an Act of Parliament, and eligible for pension after service for a comparatively brief time, should be taken into serious consideration by the Executive when it is proposed to make rules and regulations for the various District Asylums in Ireland. He would like to have the feeling of the meeting generally on the subject, and he was anxious, at any rate, to bring it under their notice in view of any possible further development.

Dr. FINEGAN suggested that a resolution should proceed from that meeting asking the Inspectors of Lunatics to take the matter into consideration.

Dr. GARNER dwelt upon the utter incompatibility of the idea of a strike with the discipline of an asylum. He pointed out that attendance on the insane was not a trade, and he said he was confident that if an attempt of this kind was made by the attendants in his asylum he would be able to deal effectively with it. He agreed that the same conditions for meeting this society might not be so favourable elsewhere, but if one of his attendants took any part in it he would forthwith suspend him, and recommend the Board to dismiss him. On the whole he was disposed to think it would not be wise to make too much of the incident before them.

Drs. FINEGAN and O'NEILL favoured the suggestion to invite action on the part of the Inspectors, but at the same time they felt certain of their ability to prevent the Society getting any recognition in their asylums.

The following resolution was proposed by Dr. O'NEILL, seconded by Dr. FINEGAN:—"That the attention of the Inspectors be drawn to the Trades Union Society of Asylum Attendants, as we believe that if it was allowed to increase it would be injurious to the best interests of asylums."

After further remarks from Drs. Woods and NORMAN,

The CHAIRMAN said possibly the discussion that had taken place would have the effect of a resolution. Besides, the subject had come somewhat suddenly on them, and perhaps, under the circumstances, Dr. O'Neill would agree that the object in view would be as well served by withdrawing the resolution.

Dr. O'NEILL said as far as he was concerned he would withdraw the resolution with pleasure.

Dr. Woods said if this Society did not die by the solitary action of the Richmond Asylum Board the subject could be again brought up at the Annual Meeting of the Medico-Psychological Association, and they could then take action. They might be a little too hasty just at present.

After some further discussion the resolution was withdrawn.

THE TRAINING OF ASYLUM ATTENDANTS.

Dr. FINEGAN introduced the subject, dealing especially with the way in which papers were examined. He thought that too many of the candidates who presented themselves were allowed to pass. In some of the results announced recently he noticed that all the candidates succeeded. He feared that there was an unwillingness to "stick" candidates. As far as the Mullingar Asylum was concerned, all that went up were able to read and write, and passed (laughter). He suggested that they should consider whether it would not be advisable that an Educational Committee should be appointed who would either mark the papers or select examiners for the purpose.

Dr. Woods said that he had raised this question in London at the Annual Meeting, and he quite agreed with the views of Dr. Finegan in favour of common examiners for all the papers. The duty of examining all the papers should be referred to one person or an Examining Board, and no candidate should be allowed to pass who did not come up to the common standard. Dr. Finegan's statement about all being allowed to pass was hardly borne out by the facts, which showed the proportion of failures to be about 23 per cent., at all events in Cork and Limerick. In some asylums he feared there was a system of cram, and he thought they ought to extend the lectures over a long period. Those who did not intend going for the next examination should be compelled to attend, and promotion should only be given to those who passed the examination.

Dr. O'NEILL mentioned a scheme which he had brought before his Board which would benefit the attendants who received the certificate of the Medico-Psychological Association, and instanced the case of one nurse who had been in his asylum only two years whom he had promoted because she had passed the examination. He thought that nurses should be compelled, or that some pressure should be brought to bear on them to go in for the examination. He agreed with what Dr. Finegan had said about the necessity for greater care in the examinations. It certainly seemed strange to say that out of twenty or twenty-one names in one asylum not one was stopped. Marks ought to be given to attendants and nurses for general conduct, condition of their wards, appearance of patients, and general character. Of course if that could not be done some provision should be made to recognise these evidences of care in duty.

Dr. Woods said a resolution was adopted by the Cork Board eighteen months ago to give £2 per annum to each one who obtained the certificate of the Association, and the recent circular showed that the Privy Council were prepared to adopt that proposal. He was not satisfied with that, and he had got the Cork Board to sanction a grant not exceeding £100 per annum which would be divided amongst those attendants who during the year had shown special merit and performed their duties in a perfectly satisfactory manner. Result fees in Irish Asylums would be a valuable incentive to the men doing their duty. Attendants who worked in an exceptional way were entitled to some recognition from the Governors.

Dr. NORMAN said he was very much struck by the extreme kindness of heart which Dr. Finegan showed by the manner in which he suggested he could not find it possible to "stick" an attendant. He (Dr. Norman) was glad to say that the general records of examinations in this country hardly bore out this extremely roseate view. At the November examination in the Richmond Asylum, eighteen attendants presented themselves. One retired and four were stopped. In that examination he was associated with Dr. Molony. They got wonderfully few papers incorrectly spelt, and some of them would not suffer in comparison with the papers of the medical students of the Physicians and Surgeons Conjoint Examination. He thought there would be great practical difficulty in carrying out the suggestion to refer all the examination papers to one person. With regard to Dr. O'Neill's suggestion that marks should be given for general conduct that was wholly impossible in connection with this examination. What they should aim at was that every attendant should be compelled to pass the examination. If they did not do so they should not be retained.

The CHAIRMAN said that of the five attendants in his asylum who went in for the examination all passed, but he regretted that he could not anticipate such good results in future. Naturally the best men would go up for the earlier examinations. Many would drop out before an examination, and it was not surprising that there were so few failures. Lectures and the setting of papers were very valuable aids to attendants and nurses.

Dr. NORMAN said his assistants had conducted weekly examinations as well as lectures for the nurses of the Richmond Asylum. He regarded these weekly examinations as of great value.

The CHAIRMAN said any resolution with regard to having the papers examined by a committee must be brought up at a future meeting, but that if this meeting was of Dr. Finegan's opinion it would be competent for them to send forward a recommendation which could be discussed and dealt with by the Annual Meeting.

After some further discussion it was agreed to send forward a suggestion to the Annual Meeting that in future papers should be marked and signed by a committee.

THE ATTENDANTS' HANDBOOK.

Dr. NORMAN said that though his name appeared in the book as one of the authors, he should disclaim that credit, as he had very little to do with it. The work was chiefly done by his Scottish and English coadjutors. He would suggest to the meeting that the members of the Irish Division of the Association should lay before him (Dr. Norman) any suggestions they had to make with regard to additions or amendments, and he would forward them to the proper quarter, and he could ensure their careful consideration.

The suggestion was agreed to.

NEXT MEETING.

Dr. WOODS read a letter from Dr. Hetherington, inviting the Irish Division of the Medico-Psychological Association to hold their next meeting in Londonderry.

It was agreed to accept the invitation, and cordial thanks were expressed for the offer of Dr. Hetherington. The date of the meeting was not fixed, but the general feeling was in favour of the second week in August.

A CASE OF CHOKING AND ITS SEQUELÆ.

Dr. CONOLLY NORMAN read a paper on "Accidental Choking in Asylum Practice." He described a case of an elderly alcoholic woman, who, when convalescent, choked herself by bolting her food at dinner. The speaker had performed tracheotomy and re-established respiration, but the patient died about an hour later, after exhibiting indications of bulbar mischief. Post-mortem, an extreme condition of atheroma of all the cerebral arteries was found to have existed; two small aneurisms (unruptured) of vessels pertaining to the circle of Willis; numerous miliary aneurisms; a pontal hæmorrhage and an extensive hæmorrhage invading the posterior portion of left internal capsule. The speaker regarded

the pontal hæmorrhage as the cause of death, and both the hæmorrhages as the result of straining brought about by the choking. He dwelt at some length on the interesting features which the case presented, and the rarity of similar records in literature.

PATHOLOGICAL DEMONSTRATIONS.

Dr. DANIEL RAMBAUT, Assistant Medical Officer and Pathologist, Richmond Asylum, Dublin, gave a demonstration of many of the more recent histological methods for cortex cord and medullated nerve fibres. Among them were some excellent examples of Berkley's modification of the Golgi Cajal silver method, as mentioned in *Brain* (winter 1895). In many of the sections there was very little incrustation, and in some the cell showed fine lines running from one pole to the other. Dr. Rambaut also showed some good examples of Cox's method as described in Ramon y Cajal's *Nouvelles Idées*, and also examples of the methods of Weigert-Pal, Lissauer, Wolters, Vassale, Azoulay, Nissl, and many sections showing pathological changes in the cortex made by Bevan Lewis' fresh freezing method.

AFTERNOON MEETING.

CLINICAL DEMONSTRATION.

The afternoon meeting was held in the wards of the Richmond Asylum. Dr. CONOLLY NORMAN exhibited: (1) An extremely well-marked case of tabetic arthropathy (Charcot's disease) affecting both knee joints in a female general paralytic. (2) A destructive affection of one knee joint, resembling Charcot's disease, occurring in a male general paralytic of the spastic type. Dr. Norman said that he had recently seen several cases of Charcot's disease in general paralytics; one, affecting both knees, in a woman who died some months ago; another, affecting both knees, in a man whose mental trouble had been preceded by ataxy, of which the first overt symptoms had been bladder crises. The latter case he had intended to exhibit at this meeting, but the patient died a few days ago. (3) Two cases, a male and a female, of contracture with deformity of the legs resulting from béri-béri, from which affection these patients had suffered when it visited the Richmond Asylum in the autumn of 1894. (4) A case of alcoholic peripheral neuritis, in which the characteristic amnesia, at first well marked, was passing off, and the patient had developed delusions of persecution (poisoning) as a means of accounting to herself for her loss of memory. (5) Several cases of alcoholic amnesia without neuritic. (6) Two cases of bulbar paralysis with insanity. (7) Eight cases of general paralysis in women to illustrate the hypochondriac types of the disease. (8) Cases of general paralysis in men to illustrate the paranoiac (persecutory) types of the affection. Two of these men had attempted suicide.

SPRING MEETING OF THE SOUTH WESTERN DIVISION.

The Spring Meeting of the South Western Division of the Medico-Psychological Association was held by kind permission of Dr. Lionel Weatherly at Bailbrook House on Tuesday afternoon, April 14th. Dr. Nicolson presided over a numerous attendance, among those present being Drs. Benham, Aveline, Eager, McBryan, Wade, Jas. Stewart (Clifton), R. S. Stewart (Bridgend), Bower, McWilliam, Weatherly, Cobbold, Macdonald (Hon. Secretary), Hanbury, Deas, Fox, Mercier, Aldridge, and Iles.

RESOLUTION OF CONGRATULATION.

The minutes of the Exeter meeting having been read and signed by the Chairman, Dr. WEATHERLY moved a vote of congratulation to the Chairman on his appointment as Lord Chancellor's Visitor. This having been voted by acclamation, the CHAIRMAN expressed in very warm terms his appreciation of the expression of the feeling of the section.

ELECTION OF NEW MEMBERS.

The CHAIRMAN read the name and proposers of the following candidate for election:—WILLIAM READER HANBURY, Assistant Medical Officer, County Asylum, Dorchester. Proposers: Dr. P. W. Macdonald, Dr. Ewan, Dr. Weatherly.

The CHAIRMAN remarked that unless there was any appearance of negation the gentlemen named would be declared elected.

Dr. MERCIER said without in any way wishing to wrangle over the course pursued he should like to hear from the Chairman whether candidates could be elected at a divisional meeting which every member had a right to attend, the agenda paper of which had not been circulated generally to members of the Association.

After considerable discussion, in which Drs. Macdonald, Weatherly, and Stewart took part,

The CHAIRMAN—I rule we are in order in electing these two members to-day. The question is one that may be brought before the Council or general meeting of the Association.

ELECTION OF HONORARY SECRETARY.

The CHAIRMAN said although he had had no advice on the matter he did not think they need go far to seek an honorary secretary for that division (hear, hear). They could not do better than ask Dr. Macdonald to continue in the position.

Dr. DEAS seconded the proposition to submit Dr. Macdonald's name to the Council, and it was carried with acclamation.

RECOMMENDATION TO THE COUNCIL.

The meeting then proceeded to select names to be submitted for the consideration of the Council when making nominations to fill vacancies at the next Annual Meeting.

After discussion, a resolution to submit the names of Dr. Benham and Dr. Stewart (of Glamorgan) was carried *nem. con.*

Drs. BENHAM and STEWART briefly acknowledged the compliment, assuring the meeting that if their services were called upon they would strive to carry out the duties to the best of their ability.

THE NEXT MEETING.

Dr. MACDONALD announced that an invitation had been received from Dr. Soutar, of Barnwood House, for the Division to hold their next meeting at Gloucester. The meeting that day was to have been held there.

Dr. DEAS asked if this would be long enough for Gloucester to rid itself of the small-pox.

The CHAIRMAN—They give it two years. Perhaps, however, it will be an encouragement to the Gloucester people to hope.

The meeting was fixed for Tuesday, 20th October, at Gloucester conditionally.

NON-SPECIALIST APPOINTMENTS TO ASYLUMS.

Dr. MACDONALD said under the head of general business he wished to say one or two words respecting an editorial that had appeared in the *Journal of Mental Science* under the heading of "Non-specialist Appointments to Asylums." He felt very strongly that if the Assistant Medical Officers of this country were passed over in the manner they had lately been, and according to rumour were likely to be again, he thought they as an Association should do something to raise their voice against what could only be considered unjust and unfair to a large body of able men (hear, hear). It came to this, that if when Assistant Medical Officers spent so many years of their lives in trying to fit themselves for the senior posts, and when vacancies arose they should be given away to those who had never spent an hour as an officer within an asylum, he did not think they as Asylum Medical Officers could consider it right or proper.

Dr. STEWART (Clifton) said he should be pleased to second the proposition, as one who was formerly an Assistant Medical Officer. He thought they, as an Association, should approach the matter on two grounds, not only that they considered from their knowledge of those who had been working in this specialty that they would be the most fit and proper men, but on another and more important ground, viz., that it was for the benefit of the public that the best possible skill should be taken advantage of. He considered that any man whose

duty it was to take charge of a large number of the insane and carry on the important work which it fell to the lot of a Medical Superintendent to engage in, should be one who had had special experience. He regarded it as the duty of the Association to educate the public on the matter, and to lay the case clearly before them. He was inclined to propose as an appendix that it should be sent to the Chairman of every County Council in England. He thought they would be doing in this matter what would be to the advantage of the country at large as well as for the promotion of the good of their own specialty.

Dr. BENHAM thought they might go a step further. Probably they had noticed that in respect to some of the recent appointments of Medical Superintendents for asylums there had been a statement that no pension would be given. It might happen that a man who had served a considerable time in an asylum might like to retire, and his retirement might even be in the interests of the institution of which he was at the head, but under the system of there being no pension he might possibly be prevented because he had been unable to make provision for old age. It might happen that committees who would be glad at a certain period of advanced age to get rid of officers would feel themselves debarred from doing so under the arrangement to which he was referring, because they would be practically turning an old servant out on the world. He thought a clause should be inserted in the resolution to the effect that that branch of the Association viewed with regret that in connection with recent appointments to the Medical Superintendentships of asylums no regard had been paid to the necessary provision for old age.

The CHAIRMAN thought it would be a pity to overload the one idea. The pension question might form the subject of a separate representation, but he did not think it would be well to put it in as a clause of the resolution. With regard to the resolution itself, he thought it scarcely did the extent of the injustice justice by referring merely to the unfairness to Assistant Medical Officers. He thought they would make their case very much stronger by pointing out that the appointment of inexperienced individuals to the posts of Medical Superintendent was a distinct disadvantage to the well-being of the patients. That opened up a much bigger public question than that having reference simply to the injustice to Assistant Medical Officers, the words of the resolution in respect to which they all appreciated most thoroughly. Neither ought they to ignore the fact that it would after a time be impossible to find medical men applying for the junior billet if there were no likelihood of their having a reasonable chance of promotion to the senior office. The question was one of the utmost importance in regard to the proper treatment of patients and the proper administration of the asylums themselves, and no one knowing the circumstances could cavil at a resolution of this sort going forward.

Dr. BOWER thought the side of the question opened up by the Chairman of the greatest importance. He was strongly in favour of an addition being made to the resolution representing the loss which would ensue to the patients and the general management of asylums by the appointment of persons unacquainted with the treatment of mental disease and with asylum management. He thought the question would appeal to all committees of asylums, and suggested that a copy of the resolution be sent to all the Managing Committees. It might then have some effect, but for his own part he thought it would be utterly useless to send it to the Chairmen of County Councils.

Dr. STEWART concurred with Dr. Bower's suggestion, and thought that it would be advisable for the Secretary in forwarding the resolution to express the hope that it would be laid before each Committee at their next meeting.

Dr. ALDRIDGE thought it might be useful to review the arguments used in justification of the last appointment. It was argued that a Medical Superintendent of an asylum did not have much to do with the treatment of the patients, leaving that to the Assistant Medical Officers, but busied himself more with the administration. Further, that a gentleman who had had to take care of the health of a town had learnt something in administration, and had also got what was considered to be a first rate requisite for the Superintendentship of an asylum

—a good nose for smell. (Laughter.) This contention, however, rather refuted the theory that Assistant Medical Officers should not be appointed, because if he had had the treatment of patients left to him surely he was better qualified to treat them when he became the Superintendent than a man who had probably never seen half-a-dozen lunatics in his life. (Hear, hear.) There was a letter only the other day in the *British Medical Journal* from a late Assistant Medical Officer on this very point, which supported the contention. It was from an Assistant Medical Officer who had served two or three years, and had then gone out of the specialty. He thought the argument a very forcible one, and it would be well to lay the fact clearly before all Asylum Committees that to appoint at the head of asylums men who were altogether inexperienced in that branch of the medical science might possibly mean a very serious thing to the ratepayers, and probably lead to some very expensive mistakes. (Hear, hear.)

Dr. MACDONALD suggested that the resolutions should be left to the Chairman and himself to frame. He thought they had fairly gathered what were the views and wishes of the meeting.

Dr. Fox said he was inclined to go further than Dr. Benham, and say that if it was improper that inexperienced men should be appointed as heads of asylums, surely it was much more improper that inexperienced medical men should be appointed to the regulation of all the asylums and of all the Superintendents. He should like to suggest that as a logical outcome of the former resolution, seeing that they were now engaged in the occupation of educating the public, it should be submitted to the discretion of the President whether or not it would be desirable to forward to the Lord Chancellor a petition from that Division to the effect that in future all appointments of Medical Commissioners might be made exclusively from gentlemen who had had previous experience in the management of asylums. (Laughter.)

Dr. BOWER—And Deputy Commissioners. (Renewed laughter.)

Dr. Fox—Yes, as far as I am concerned.

The PRESIDENT—It opens up a very large field. (Laughter.)

The following are the resolutions as ultimately framed:—

“That in all appointments to the office of Medical Superintendent of an Asylum for the Insane, previous experience as an Asylum Medical Officer should be required.”

“That the appointment of candidates who have had no previous experience in the treatment of the insane is detrimental to the best interests of the patients and unjust to the large body of Assistant Medical Officers.”

“That the Association be asked to take such steps as it may deem advisable with the view of making representations on the subject to all interested authorities.”

“That owing to the anxious and trying, not to say dangerous nature of the duties, and the great necessity of securing the best candidates, the office of Medical Superintendent to an Asylum for the Insane should in every case carry with it a retiring allowance.”

“That this meeting views with regret the fact that in some recent appointments to the post of Medical Superintendent in this country it has been announced that no pension will be granted.”

THE REPORT ON CRIMINAL RESPONSIBILITY.

In accordance with a resolution passed at the last meeting of the Division, the meeting proceeded to consider the report of the Committee on Criminal Responsibility.

Dr. WEATHERLY in opening the discussion expressed the opinion that it would not do for them as an Association to accept the report, for the simple reason that they had made in the past very definite attempts to get the law altered and they were still having before them constantly reasons why the law should be altered. They had had since their last Annual Meeting a large sectional meeting of the Psychological Section of the British Medical Association, and here the consensus of opinion was that the law was wrong, and required amendment. They also found the editor of the *Times* recently allowing a leading article to appear in that

journal condemning the law, pointing out the need there existed for a change and the advisability of the lawyers meeting and taking some action in the matter. If they accepted the report it would appear that they were contented and that everything was as it should be. The arguments which he adduced before the sectional meeting of the British Medical Association had by cases since been strongly exemplified. He said then, and still strongly maintained, that the fact of so many people being reprieved after sentence of death proved all the more that the law must be wrong, for while a man was sentenced to death under it in a court of justice, it very frequently reprieved him in the criminal cell. Although they admitted that things were improving very much, and realised that the judges were very much more inclined to allow that latitude which ought to be allowed medical witnesses in the witness-box, and although they were satisfied that much greater justice was done to the criminal lunatic in the present than in the past, still he thought it would be more advisable to allow the report to lie on the table than to actually accept it, and for the sub-committee to remain as a standing committee to watch the question on behalf of the Medico-Psychological Association. It seemed to him that there was a great deal of watching required, and though he understood that Dr. Mercier had undertaken to watch these cases, it appeared to him that it would be better for the sub-committee to act instead of any member individually. He suggested that a resolution should be moved to this effect.

Dr. MERCIER remarked that a notice was put in the Journal requesting every member of the Association to be good enough to send reports of cases occurring in their neighbourhood for publication in the Journal. That notice, however, had not once been responded to. (Laughter.) He had had to collect the cases himself by sending to the proprietors of the local journals, and from the reports of the ordinary daily papers. Dr. Weatherly had evidently become aware of several cases which he had not reported and which ought to have been reported in the Journal. As he had stated that they showed his own view of the matter, Dr. Weatherly had himself to blame that these cases had been omitted. As to the subject generally, he did not wish to enter largely upon it, because it would come up again at the Annual Meeting. But with regard to one case referred to by Dr. Weatherly of a man being subsequently reprieved on the ground of insanity although found guilty in court, it was a fact which he omitted to mention that other circumstances were discovered after sentence which showed the man's insanity.

Dr. WEATHERLY said he quite agreed with Dr. Mercier on that point. It was shown that the man was suffering from inflammation of the base of the skull.

Dr. Fox said he had not read the report of the committee very recently, but it had appeared to him that it did not sufficiently condemn that silly old formula of the knowledge of right from wrong as being the test of judicial responsibility. He was bound to say that as a scientific society, as a society of physicians conversant with the mental powers of the huge majority of their patients, they should be extremely reluctant in accepting any report which had even the slightest tendency to favour a formula that was liable to work the greatest possible mischief and injustice in the determination of criminal responsibility. They found that all the arguments raised were founded on capital cases, but there was a very considerable number of cases in which the plea of insanity was raised that were not capital cases. In these cases as in others the injustice and the scientific wrong were equal with what they were in capital cases, only supposing it was raised, and unsuccessfully raised, it was much less likely to be put right than when grave consequences followed. As a private member of that Association he should strongly vote for further time before the report was accepted in its entirety. (Hear, hear.)

Dr. STEWART (Clifton) described a legal case in which he had been concerned in illustration of what Dr. Fox had stated. As to the matter before them, he thought that Dr. Weatherly had made out a very good case for their exercising a great deal of care before committing themselves to any report which would make permanent an opinion which he doubted very much whether the whole Associa-

tion or the greater part of it would be prepared to abide by, if placed in the witness box.

Dr. WADE proposed a resolution in accordance with Dr. Weatherly's suggestion, that the report be allowed to lie on the table and that the sub-committee be the standing committee to further watch the question. (Hear, hear.)

Dr. ALDRIDGE seconded.

Dr. MERCIER said he should like to explain a point in regard to which there appeared to exist a good deal of misapprehension. It was stated again and again that the report thoroughly and entirely approved of the state of affairs and laws at present existing. The report did nothing of the kind. All that the report did was summed up in the closing paragraph. In this it was stated that the committee did not at present see their way to make any recommendation for alteration in the law. This was a very different thing to expressing complete and entire approval with the law as it stood.

The CHAIRMAN said that there was always the great risk of wandering away from the point at issue on a question that touched them all so much personally. As had already been explained the report of the committee arose out of a special group of circumstances and had relation merely to the opinion formed by that committee on the working of the law in recent years, in view of the extended knowledge that medical men possessed, and the extended confidence which the judges were showing medical men who gave evidence before them. It was suggested at the meeting at Bristol when the original committee was formed that they should approach the Lord Chancellor directly in the matter, but personally he was very strongly opposed to that because he thought it would be unseemly for them to go with an insufficient case to him, before the matter had been considered by the Association. He did not agree with Dr. Fox that they should drag minor cases into the discussion. It was a very good and proper question on its own basis, but they were dealing with the question of hanging individuals where they went beyond recall. His own experience from the great number of cases he had gone to see was that it was most important and vital that the question should sometimes be reconsidered after trial. He felt that before trial, at the trial, and after trial, insane people who did criminal acts were thoroughly and properly considered in all their relationships, and it was quite possible that they might do more harm than 'good by being hysterical over a question of such grave import. He spoke strongly from his own experience in advising that no active steps should be taken that would bring the Association into a false position with the judicial authorities of the country, and with the members of the community. There might be injustice done, but he thought it had been reduced to a very minimum—within human range, none he would say wilfully or intentionally, either by the judges or by the medical men. It was hardly fair, or advisable he thought, that they should be prominent in their outcry when they were, as yet, unable to supply advice in the nature of a remedy for the existing state of things. Referring to the resolution before the meeting, he thought it would be a mistake that the sub-committee should stand as a permanent committee. The Home Office was pleased at all times to get from any member of the community evidence that any particular case required, and to review it. The matter was one that rested as much with members of the Association individually as with a committee.

Dr. WEATHERLY said he was not at all desirous of any active steps being taken. He merely went so far as to say that he did not think the Association should commit itself to the report.

Dr. WADE—I am quite prepared to withdraw that clause of the resolution referring to the standing committee.

The CHAIRMAN—I don't think, then, if the report is merely allowed to lie on the table, it will do any harm to the country. (Laughter.)

Dr. STEWART—It has at least brought many interesting facts before us and I think we are greatly indebted to the committee for their work. (Hear, hear.)

THE NURSING STAFF IN ASYLUMS.

Dr. MACDONALD, after various postponements, extending over a period of some

18 months, then read his paper on "The Nursing Staff in Asylums." (See Original Articles.)

THE LUNACY ACT.

Dr. R. S. STEWART then read notes on "The Special Reports and Certificates required by Sec. 38 of the Lunacy Act, 1890, and Sec. 7 of the Act, 1891." (See Original Articles.)

The CHAIRMAN at the conclusion of the paper thanked Dr. Stewart, on behalf of the meeting, for his contribution, and though it was not exactly one to give rise to any great discussion, it would he hoped be open for inspection in the pages of the Journal, for he was sure that any method that could be introduced to simplify and keep straight the cumbersome working of the Act in this relation was to be welcomed. (Hear, hear.)

Before parting he thought they would like him to ask Dr. Weatherly and Dr. Cobbold to accept their sincere thanks for their great kindness in not only being always so ready to provide them shelter, but for entertaining them so freely, generously, and handsomely. (Applause). He also congratulated the members of the Division on attending in such large numbers.

The members and several visitors afterwards dined together at the Grand Pump Room Hotel.

REPORT OF THE DEPARTMENTAL COMMITTEE ON PRISONS 1895.

In June, 1894, a Committee was appointed by the Home Secretary (Mr. Asquith) to inquire into certain questions bearing upon the administration of prisons, and the classification and treatment of prisoners. The Report of the Committee is dated April, 1895. We here abstract from the summary of principal recommendations of this Report certain which have special interest for alienists.

(i.) That candidates for medical appointments in prisons should be required to show that they have given special attention to lunacy, and that the medical staff in Holloway and other prisons similarly circumstanced be strengthened.

(ii.) That weak-minded prisoners should be concentrated so far as is possible in special prisons, and should be under special medical supervision; and that it should be considered whether it is right to treat such persons as ordinary criminals.

(iii.) That two or more prisons should be selected as training schools for all ranks of the prison staff, and be placed under the charge of the most experienced officers in the service.

(iv.) Habitual criminals to be kept as a class apart from the other prisoners. It should be considered whether a new form of sentence might not with advantage be placed at the disposal of the judges by which these prisoners could be segregated under special conditions for long periods of detention.

(v.) Prisoners sentenced primarily for drunkenness should be specially treated in prisons or parts of prisons set apart for them.

(vi.) That an additional member of the Prisons Board should be appointed, who should be a medical man.

The above is a summary of the recommendations. We may note more fully certain of the suggestions as contained in the body of the Report.

In reference to (i.), the Belgian system of medical inspection of convicts is favourably noted. In Belgium three special medical officers, alienists by training, have each the care of a certain number of prisons, the total number of which is for this purpose divided into three divisions. Appendix (i.) of the Minutes of Evidence furnishes, in answer to the question "Is any special arrangement made for the study of insanity in prisons?" the methods employed in the principal States of Europe and in America. With the exception of France, Germany (Prussia), and Austria—and even in these the arrangements cannot be described as satisfactory—in no country is the study of insanity in prisons

specially provided for. (ii.) Weak-minded prisoners are said to supply about 2 per cent. of the prison population. The treatment of these has always been found to present peculiar difficulties. The short terms of imprisonment to which they, for the most part, are sentenced, would seem to be of but little avail, since they return frequently a few days after discharge. In other cases they spend their lives in circulating between prison, asylum, and workhouse. The Committee agrees with the various witnesses as to the desirability of establishing a special institution for this class. It considers that "it is indeed a question whether the epileptic and obviously weak-minded class should be sent to prison at all." (iii.) Those in the "training schools" referred to should, it is recommended, "go through a course of systematic and scientific instruction. Lectures should be given by experts in criminal anthropology, and every man who enters the service should have a clear knowledge of what can and ought to be done in his personal dealings with prisoners, over and above the formal discharge of his routine duties." The immediate organisation of these establishments is recommended. It is pointed out that under such a system (the application of which is still further elaborated in the Report) a higher class of prison warders would be produced. (iv.) It is recognised that habitual criminals are a most undesirable element in a mixed prison population, and that they require special treatment. A considerable section of them regard short sentences with "comparative indifference." Serving their time quietly they all along have the full determination to revert to crime on discharge. It is pointed out that, as loss of liberty would eventually, to such persons, prove the chief deterrent, long periods of detention during which they would be forced to work, though under less onerous conditions than those of hard labour, are very desirable in their case. (v.) The Committee's inquiries confirm the recommendation of the Departmental Committee on Inebriates, that magistrates should have power to commit for lengthened periods habitual drunkards. "The physical craving for drink is a disease which requires medical treatment. . . . Special medical treatment should be applied to them (habitual drunkards), and they should be dealt with as patients rather than criminals."

The Report closes with a memorandum on "Insanity in Prisons," by Dr. J. H. Bridges. He shows that the strong statements to the effect that the existing prison system promotes insanity, and that the number of cases of insanity occurring among prisoners is greater than it was 20 years ago, "when prison administration was less centralised," are unfounded. It has been pointed out by the Medical Inspector of the Prisons Board that the practice of sending insane persons to prison has largely increased of recent years. The remarks of the Lunacy Commissioners in the 43rd Report are quoted, to the effect that during a period of a few years prior to that Report, many medical men refused to certify insane persons, owing to fear of litigation, and thus many insane persons have not been legally dealt with. It is probable that many of these have been first dealt with as lunatics after they have committed some offence, and found their way to prison. And this brings us back to the question of the manufacture of insanity in prisons. It is clear, on inquiry, that most of the cases of insanity recorded in gaols were already insane on admission. Out of 354 cases recorded in local prisons in a given year there appeared to be only 60 in which insanity was for the first time apparent a month or more than a month after admission. The memorandum observes that "on examination at least 18 must be deducted from this number, as being judged to be insane on their trial, or as presenting obvious signs of mental unsoundness at the time when their imprisonment began." After examining the special Reports obtained by the Committee in these 60 cases, abstracts of which are given in Appendix (vii.) we have come to the conclusion that 18 falls far short of the proper number to be deducted, which reaches 48 at least; leaving at most 12 cases, who, being sane on admission, became insane more than a month afterwards. In conclusion then, with the exception of something like a dozen cases, evidence of insanity on admission was obtainable in all the cases of insanity recorded in local prisons for the year in question.

MEMORANDUM ON CRIMINAL RESPONSIBILITY.*

By W. ORANGE, C.B., M.D., F.R.C.P.

In the case of a person who is charged with an indictable offence, and who is alleged to be insane, the first question that presents itself for consideration is whether such accused person is, or is not, in a fit mental condition to be called upon to plead to the indictment, and to take his trial; for, according to the common law of England, as stated by Blackstone, in his Commentaries (Book 4, Chap. II): "If a man in his sound memory commits a capital offence, and before arraignment for it, he becomes mad, he ought not to be arraigned for it; because he is not able to plead to it with that advice and caution that he ought." And this general principle of the common law was set out more fully in a statute passed in the year 1800 (39 and 40 Geo. III., cap. 94), by which it was enacted that "If any person indicted for any offence shall be insane, and shall, upon arraignment, be found so to be by a jury lawfully impanelled for that purpose, so that such person cannot be tried upon such indictment," . . . "it shall be lawful for the Court before whom any such person shall be brought to be arraigned, or tried as aforesaid, to direct such finding to be recorded, and thereupon to order such person to be kept in strict custody until His Majesty's pleasure shall be known."

In deciding this point, whether the accused is mentally fit to be called upon to plead and to take his trial, the Courts do not appear to be in any way fettered or hampered by any rigid rule.

In Russell, *On Crimes* (Vol. i., p. 114), the test of capacity to plead to an indictment is stated in these terms:—"Whether he (the accused) is of sufficient intellect to comprehend the course of the proceedings on the trial, so as to be able to make a proper defence." If he is not mentally fit to make a proper defence, the trial does not proceed, but the accused is detained, in conformity with the statutory provisions.†

In those cases, however, where the question referred to in the preceding paragraph has been decided in the affirmative, and where it is considered that the accused is, to use the words of Russell, "of sufficient intellect to comprehend the course of the proceedings on the trial, so as to be able to make a proper defence," the accused is then called upon to plead. The trial then proceeds, and the jury are required to find, firstly, whether the accused did or did not commit the offence charged against him; and, if this question is answered in the affirmative, then to say, further, whether, at the very time of committing the offence the accused was, or was not, "insane, so as not to be responsible according to law."

The special statute relating to this matter, at present in force, was passed in the year 1883, and is entitled the "Trial of Lunatics Act" (46 and 47 Vict., c. 38). It extends to Ireland, but not to Scotland; and it will be observed that its provisions have reference only to those cases in which the accused is considered to be of sufficient mental capacity and of sufficiently sound mind to be put upon his trial.

By this statute it is enacted that "where in any indictment, or information, any act, or omission, is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane, so as not to be responsible, according to law, for his actions at the time when the act was done, or the omission made, then, if it appears to the jury, before whom such person is tried, that he did the act, or made the omission charged, but was insane, as aforesaid, at the time when he did or made the same, the jury shall return a special verdict to the effect that the accused was guilty of the act or omission charged against him, but was insane, as aforesaid, when he did the act or made the omission."

The statute then goes on to direct that "where such special verdict is found,

* Prepared for the Committee of the Medico-Psychological Association, appointed at the Bristol Meeting, July, 1894.

† See also Tuke's *Dictionary of Psychological Medicine*, p. 591, Art. "Plead."

the Court shall order the accused to be kept in custody as a *criminal lunatic*, in such place and in such manner as the Court shall direct, till Her Majesty's pleasure shall be known."

It will be observed that, whereas by former statutes a person was said to be "*acquitted* on the ground of insanity," the term "*acquitted*" is now no longer used; but by the statute of 1883, the jury are required to say, firstly, whether the accused is or is not guilty of the offence charged against him; and then, if they say he is guilty, they are further required to say whether he was sane or insane at the time of its commission.

It will, further, be observed that in those cases where a person is declared by the jury to have been guilty of the offence charged against him, but to have been insane at the time of its commission, the Court is specially required to order such person to be kept in custody as a *criminal lunatic*; and he is thus brought under the operation of special statutes, which have been framed with the double object of providing for the due care and treatment of the individual, and also of affording to the public the protection, which they have the right to require, against the possible commission of hurtful acts by the same individual, in the future.

And now we come to the main question, namely, the precise interpretation that is to be placed upon the words of the statute, "insane, so as not to be responsible, according to the law, for his actions, at the time when the act was done, or the omission made."

Lord Denman, in the course of his charge to the jury, in Oxford's case, laid down the general principle that "Every sort of insanity and every mode of proving it must have reference to the particular object with which it is laid before the Court."

And in the case now under consideration the particular object is to determine whether the insanity is of such kind and of such degree as to render the accused person who is the subject of it "not responsible, according to the law, for his actions."

It is with reference to the determination of this particular point that it becomes necessary to consider the answers that were returned by the bench of judges, in the year 1843, to certain questions put to them by the House of Lords; inasmuch as it is generally held that those answers constitute the leading authority by which the Courts are guided in directing juries in cases of this description.

The resolution, which the Committee was appointed to consider, would appear to indicate, indeed, that the terms of those answers were regarded as being the matter to which the attention of the Committee would be chiefly directed, although the words "to investigate the whole subject" would show that its attention was not to be entirely confined to that one point.

The circumstances under which the questions were put to the House of Lords are so well known as to require only the very briefest recapitulation.

An insane man, named Daniel McNaghten, who laboured under insane delusions of the kind commonly known as delusions of persecution, and who insanely imagined that his supposed enemies were gradually killing him by their persecutions, conceived, at last, the insane idea that the Prime Minister was responsible for the continuance of these supposed persecutions, and that the only way in which he could put a stop to them would be by taking his life. Actuated by these monstrous delusions, he, in the end, fired at, and killed the Prime Minister's Private Secretary, whom he mistook for the Prime Minister himself.

In due course he was tried, with the result that the jury found, as their verdict, that he was insane at the time of committing his offence.

So tragic an event produced, naturally enough, a profound sensation, and it is scarcely to be wondered at that some difference of opinion was expressed with respect to the verdict.

In the discussions which ensued in the House of Lords*, it would appear that three of the Law Lords, viz. Lord Lyndhurst, Lord Cottenham, and Lord Campbell, were of opinion that the verdict was a right one; whilst Lord Brougham

* *Hansard*, 3rd series, vol. lxxvii., pp. 714-744.

stoutly maintained the contrary, and said: "If the perpetrator knew what he was doing, if he had taken his precautions to accomplish his purpose, if he knew at the time of doing the desperate act that it was forbidden by the law, that was his test of sanity;" and then his Lordship went on to add that "he cared not what judge gave another test, he should go to his grave in the belief that it was the real, sound, and consistent test."

Notwithstanding, however, that Lord Brougham thus forcibly expressed his disregard for the opinions of other judges, he yet urged, and urged so strongly as to overcome the wiser counsels of Lord Lyndhurst, that certain questions should be put by the House of Lords to the whole bench of judges, in order that they, in their answers, might formulate the criteria of criminal responsibility, in cases of alleged unsoundness of mind.

As a result of the discussion which took place in the House of Lords, on March 6th and 13th, 1843, five questions were put to the judges, by whom, after taking ample time for deliberation, answers were returned on June 19th of that year.

The terms of those questions, and of the answers thereto, will be found in the pages of *Clark and Finnelly's Reports*, Vol. x., p. 200; or at page 201 of *The Insane and the Law*, by Pitt-Lewis, Percy Smith, and Hawke; or at page 310 of *Hack Tuke's Dictionary of Psychological Medicine*.

It will be observed that the judges themselves had no desire whatever that such questions should be put to them. They did not, of their own accord, go out of their way to make rules. Much against their inclination, they did their best to answer abstract questions which, probably, ought never to have been put to them.

The terms of these answers have, indeed, been subjected to much criticism from various quarters.

The late Sir James Fitzjames Stephen, in his *History of the Criminal Law of England*, observes (Vol. ii., p. 154): "I cannot help feeling, however, and I know that some of the most distinguished judges on the bench have been of the same opinion, that the authority of the answers is questionable, and it appears to me that when carefully considered they leave untouched the most difficult question connected with the subject, and lay down propositions liable to be misunderstood, *though they might, and I think ought, to be construed in a way which would dispose satisfactorily of all cases whatever.*"

And in another passage the same writer refers to them as "mere answers to questions which the judges were probably under no obligation to answer, and to which the House of Lords had probably no right to require an answer, as they did not arise out of any matter judicially before the House."

It will be remembered also that Mr. Justice Maule declined to concur in the answers given by the other judges, and said that he would have been glad if his brethren had joined him in praying to be excused from answering these questions, as he feared that the answers "might embarrass the administration of justice when they were cited in criminal trials."

And, if we descend from the bench to the bar, we find the late Mr. Serjeant Ballantyne writing as follows in the volumes of recollections published by him in 1882: "The judges were summoned by their lordships to express their opinion upon the law applicable to insanity in criminal cases. It seems to me surprising that they did not point out that such a proceeding was extra-judicial, and that their opinions could only properly be given upon certain facts arising before them in their judicial capacity, and that what was asked of them was to make a law in anticipation of facts that might hereafter arise. . . . As might be expected, being called upon to found abstract opinions, with no facts to go upon, they have not greatly assisted the administration of justice."

If we turn now from the question of the authority of the answers to the question of their scope, we shall find that great legal authorities are not all of one mind either upon this subject. And, thus, whilst the late Lord Chief Justice Cockburn (in a letter on the Criminal Code Bill, ordered by the House of Commons to be printed on the 6th of June, 1879) refers to the answers as if they contained only so much

* *Some Experiences of a Barrister's Life*, by Mr. Serjeant Ballantyne. 1882; Bentley. Vol. i., p. 246.

of the law as was necessary to answer the questions that had been submitted to the judges, on the other hand Lord Wensleydale, who, as Mr. Baron Parke, had taken part in the preparation of the answers, spoke of them, in the evidence given by him before the Capital Punishment Commission of 1865 (Question 362), as if he regarded them as embodying the whole of the law on the subject.

If it were thought that any further justification were needed by the Medico-Psychological Association for raising the question now under consideration, such justification would be found in the recent utterances of two judges so eminent as Mr. Justice Hawkins and the late Lord Chief Justice Coleridge. In the course of the trial, for murder, of a man named George Pearsall, reported in the *Worcester Journal* for Saturday, February 18th, 1888, Lord Coleridge is reported to have said that "he considered that judicial decisions on questions of insanity were bound by an old authority which, by the light of modern science, was altogether unsound and wrong." And, further on, that "there was no more painful part of the duty of those who had to administer the law than the matter of insanity. The law which existed upon the subject, and which he was going to lay down to them as law, was not incapable of being so interpreted as to do terrible injustice." And then, further on, Lord Coleridge said "that the law was administered now, he was most thankful to acknowledge, in a different spirit."

The result of the trial in this case was that the jury found, as their verdict, that the accused "was guilty of the act, but that he was insane at the time he did it."

In the case of Anthony Ware, reported in the *Shrewsbury Herald* for January, 24th, 1885, Mr. Justice Hawkins, in his charge to the Grand Jury, called attention to the case of this man, charged with murder at Bicton Asylum, and said "there had been a great deal of discussion as to how far Ware was responsible for his actions, being a confirmed lunatic." And, further on, that "it would, of course, be absurd to suppose that in this matter Ware was himself responsible for his actions, yet the law with respect to the responsibility of criminal lunatics seemed to him to be in a very unsatisfactory state;" and, further on, that "more than one of the judges had expressed a desire that the law on the subject should be reviewed, and a little more definite understanding arrived at."

His Lordship, however, at the conclusion of his remarks, added that "the Clerk of Arraignment had just handed him a letter from the Public Prosecutor, in which it was stated that no indictment would be preferred against him (Ware), as he had already been removed to Broadmoor Lunatic Asylum."

In looking through the records of the various discussions and criticisms to which the terms of the judges' answers have, at different times, been submitted, the attention is especially arrested by the discussion which took place in the year 1874, when a proposal was made to codify the law of homicide generally, and when, therefore, the codification of the law as to the effect of madness, in cases of homicide, was proposed, as a part of the general scheme.

A Bill, "to consolidate and amend the law relating to Homicide," was prepared, and brought into the House of Commons by Mr. Russell Gurney* and Mr. Lopes,† and was ordered to be printed on March 24th, 1874. The drafting of the Bill had been entrusted to Mr. Fitzjames Stephen.‡

The 24th section of this Bill, as brought into the House of Commons, was in the following terms:—

"Homicide is not criminal if the person by whom it is committed is, at the time when he commits it, prevented by any disease affecting his mind—

- "a. From knowing the nature of the act done by him;
- "b. From knowing that it is forbidden by law;
- "c. From knowing that it is morally wrong; or,
- "d. From controlling his own conduct.

"But homicide is criminal, although the mind of the person committing it is affected by disease, if such disease does not, in fact, produce some one of the effects aforesaid in reference to the act by which death is caused, or if the inability to control his conduct is not produced exclusively by such disease.

* At that time Recorder of London.

† Now Lord Justice Lopes.

‡ Afterwards Sir James Fitzjames Stephen.

"If a person is proved to have been labouring under any insane delusion at the time when he committed homicide, it shall be presumed, unless the contrary appears or is proved, that he did not possess the degree of knowledge or self-control hereinbefore specified."

This Bill, it will be remembered, was a Bill to define, consolidate, and amend the law relating to homicide generally. It consisted of 44 clauses, and the only clause touching upon the effect of madness was the 24th, which has been set out above.

The Bill was read a second time in the House of Commons on the 14th of May, and was then referred to a Select Committee, and the Report made by that Committee was ordered by the House of Commons to be printed on the 21st of July, 1874. In their Report the Committee observe that the responsibility of declaring the terms on which *it shall be lawful to take the life of a fellow creature* is the most awful that can be undertaken; and that it should not be adventured on as a test or experiment, but should be reserved until the method of codification has been perfected by numerous trials on less momentous subjects. They go on to say that "in the case of homicide we have to deal, not with technical terms, but with ordinary language, which is quite intelligible when used by a judge in directing a jury on a state of facts proved before them, but which, when reduced to abstract propositions, becomes obscure and ambiguous from the want of particulars to which the proposition applies, and from the want of a clear definition of the terms used."

After adducing other weighty reasons "against commencing to codify with the law of homicide, and above all against delegating such a duty to a Select Committee of the House of Commons," they reported that, in their opinion, it was not desirable to proceed with the Bill, and it was thereupon abandoned.

The Report made by the Select Committee was accompanied by the evidence taken thereon, which included the evidence of Mr. J. Fitzjames Stephen, by whom the Bill had been drawn, of Mr. Baron Bramwell* and of Mr. Justice Blackburn.† The Committee also appended a written memorandum, containing an elaborate criticism of the Bill, from the Lord Chief Justice (Sir Alexander Cockburn).

The first witness examined was Sir James Fitzjames Stephen. And with reference to the proposed 24th section of the Bill, which dealt with the question of insanity, he said, † "With regard to the law upon that subject (Section 24) the standard authority, as the Committee, of course, are well aware, is the opinion of the judges, given in *McNaghten's case*, although, of course, the Committee are also aware that very eminent judges have greatly doubted the constitutional propriety of putting abstract questions of that kind to the judges and getting such answers from them.

"I have heard more than one of the most eminent judges on the bench express themselves as being doubtful with regard to that authority on that ground. However, as a matter of fact, I think it will not be doubted that, at the present day, it is generally regarded as the leading authority on the subject of insanity. Now, as to that authority, I think this section varies from it slightly, but it varies from it by clearing up what I have always regarded as an ambiguity in the judgment as to a matter upon which the judges may possibly not have felt themselves called upon to give any opinion."

Sir James Stephen then went on to argue that the language of the judges, "that he (the accused party) did not know he was doing what was wrong," was intended to include "morally wrong" as well as "forbidden by law." Sir James then gave a case in illustration of his view, and went on to say, "Now, if you interpret the word 'wrong' as meaning not morally wrong but forbidden by law, that man" (the man whose case Sir James had described) "ought to have been hanged, because he not only knew that the act was forbidden by the law, but the very reason why he did it was because it was forbidden by law. I can

* Afterwards Lord Bramwell.

† Afterwards Lord Blackburn.

‡ Report, page 8.

hardly argue with anybody who says that a man" (such as the man whom Sir James had described) "ought to be hanged."

The next witness who was examined by the Committee was Lord Bramwell.

He objected both to Subsection "C" and to Subsection "D" of the proposed 24th clause, and the whole drift of his evidence was opposed to the idea of doing anything in the direction of diminishing the controlling influence which the fear of punishment might have in deterring what he termed "crazy fellows" from committing unlawful acts. He said,* "What you want to do is to frighten people, to terrify them; and the way to try who ought to be punished, to my mind, is to try who ought to be threatened with punishment."

Lord Bramwell referred to the case mentioned by Sir James Stephen, and said: "It is the case of a man who supposed that if he could be put to death he would save the world; and then he murders someone to get hanged in order to save the world. Mr. Stephen says: 'Would Baron Bramwell say that he ought to be hung?' I beg to say that is not the question. The question is, what rule you are to lay down; are you to lay down a rule that would exclude his being hung?" . . . "I would not have a law to except this case which would necessarily except others that ought not to be excepted."

Lord Bramwell also objected to Subsection "D" "from controlling his own conduct." He thought that at least this should be qualified by saying "from controlling his own conduct by the ordinary motives of mankind." He had sent to the Home Office this note,† "I vehemently protest against 'D.' What is the meaning of a man being prevented from controlling his conduct? When he is prevented it is because the preventing motives are strong enough. When he is not prevented it is because they are not strong enough. The effect of this would be to lessen the preventing motives."

Further on, Lord Bramwell said, "It is obvious that what is called an uncontrollable impulse is one as to which the deterring or controlling motives are not strong enough; and this is a proposition, in all cases, to take away from a man, in a state of mind in which he is more likely to do mischief than anything else, a deterring motive."

Being asked (Question 186) what he would say to a proposal that the clause should simply say that homicide should not be criminal where, according to the present law, it is not criminal, Lord Bramwell replied, "I think that would be a very great improvement on this Bill, for I think that, although the present law lays down such a definition of madness that *nobody is hardly ever really mad enough to be within it*, yet it is a *logical and good definition*."

Being asked (Question 187) whether Subsections "C" and "D," in his opinion, do not express the state of the law as it now is, Lord Bramwell replied, "I am certain they do not." And then, being asked whether he could state what would express it, he replied (Question 188) "When a man's state of mind is such that he does not know the nature and quality of the act he is doing, for instance, does not know that cutting a man's head off will kill him, like the man who cut off the head of another person in order to see how he looked when he woke; or when his state of mind is such that, although he may know what the result will be, he does not know that it is wrong, then he ought to be acquitted. So also, if he is labouring under a delusion of such a character that, if the delusion were true, he would be justified in the homicidal act, that is to say if he supposes that the man he kills is attacking him, and that it is necessary to defend his life; in all those cases he would be entitled to be acquitted on the ground of insanity. The common notion that a man may be acquitted merely because he is mad is erroneous."

Considerations of space forbid giving the whole of Lord Bramwell's evidence, but one other point must be mentioned. Lord Bramwell objected to the words "Homicide is not criminal" in the 24th Section, unless some words were introduced so as to ensure that persons who might be found insane under its provisions should be detained during her Majesty's pleasure.

* Report, page 26.

† Report of Homicide Law Amendment Committee, Question 183.

The next witness was Lord Blackburn.

After submitting his observations on the earlier part of the Bill, his lordship went on to say (Question 274), "The next thing that comes here is that homicide is not criminal in cases of insanity. To that I can only say that on the question what amounts to insanity that would prevent a person being punishable or not, I have read every definition which I ever could meet with, and never was satisfied with one of them, and have endeavoured in vain to make one satisfactory to myself. I verily believe that it is not in human power to do it. You must take it that in every individual case you must look at the circumstances and do the best you can to say whether it was the disease of the mind which was the cause of the crime or the party's criminal will. But this I am clear about: Whatever definition you give of insanity it should apply to all crimes."

Being then asked (Question 276) whether he had any criticisms to offer on the 24th clause as it stood in the Bill, Lord Blackburn replied, "With regard to the words 'from knowing that it is morally wrong, or from controlling his own conduct;' these are the definitions that are put in, and these agree pretty nearly with what was said in McNaghten's case, in their extra-judicial opinions, by the judges, in the House of Lords; but we cannot fail to see that there are cases where the person is clearly not responsible, and yet knew right from wrong. I can give you an instance. It was in the case of that woman of whom I was speaking, who was tried for wounding a girl with intent to murder. The facts were these. The woman had more than once been insane, the insanity being principally brought on by suckling her child too long; that was the cause that had produced it before. She was living with her husband, and had the charge of this girl, an impotent girl of about fifteen, who lay in bed all day; she was very kind to her, and treated her very well; they were miserably poor, and very much owing to that she continued to nurse her boy till he was nearly two years old; and suddenly, when in this state, she one morning about eleven o'clock went to the child lying there in bed, aged 15, and deliberately cut her throat; then she went towards her own child, a girl of five or six years of age, of whom she was exceedingly fond, and the girl, hearing a noise, looked up and said: 'What are you doing?' 'I have killed Olivia, and I am going to kill you,' was the answer. The child fortunately, instead of screaming, threw her arms round her mother's neck, and said: 'No; I know you would not hurt your little Mopsy.' The woman dropped the child, went down and told a neighbour what she had done, that she had killed Olivia, and was going to kill Mary, 'but when the darling threw its arms round my neck I had not the heart to do it.' She clearly knew right from wrong, and knew the character of her act; for some little time after that she talked rationally enough, but before night she was sent to a lunatic asylum raving mad; and, having recovered, she was brought to be tried before me at a subsequent assizes. On the definition in McNaghten's case she did know right from wrong. She did not * know the quality of her act, and was quite aware of what she had done; but I felt it impossible to say she should be punished. If I had read the definition in McNaghten's case, and said, 'Do you bring her within that?' the jury would have taken the bit in their own teeth, and said, 'Not guilty on the ground of insanity.' I did not do that. I told them that there were exceptional cases, and on that the jury found her not guilty on the ground of insanity, and, I think, rightly."

Lord Blackburn then added, "On this definition" (that is to say on the definition of the proposed 24th section) "I think you would be obliged to say that woman was guilty."

It is most important not to overlook this point. Lord Blackburn, it will be seen, distinctly expresses the opinion not only that the case which he related did not come within the terms of the answers of the judges of 1843, but also that, in his view, the proposed 24th section of the Bill of 1874 would have equally failed to cover it.

Mr. Russell Gurney then said (Question 277), "There were delusions, were

* In the sentence "She did *not* know the quality of her act," the word *not* in the printed report (page 41) would appear to be an error.

there not?" to which Lord Blackburn replied, "No. There was the subsequent evidence that before night she was so mad that they had to send her to an asylum; but before the crime, and for some time afterwards, there was nothing whatever to show a delusion. But I fear a general rule of this sort, making it a question for the jury whether the disease was the efficient cause of the act, would be leaving the thing at large. I have never been able to assign a definition satisfactory to my own mind, and will not pretend to do so."

With reference to this very striking case, so graphically related by Lord Blackburn, I have on a former occasion offered a few observations, some of which I venture to reproduce here.

The word "suddenly," which Lord Blackburn uses to express the manner in which the poor woman killed her child, is liable to be misleading. The woman became an inmate of Broadmoor, and told me all about the matter. She said that she was very much depressed and weakened by suckling her infant, and that the catamenia had returned, and she had suffered a great deal from hæmorrhage, and, on the previous day, Sunday, she knew she was "getting bad again"—to use her own phrase. Two years before she committed this murder, she had attempted to drown herself and her child, but was rescued. She says she could not accurately describe what she felt, but she remembers that she did not want to live, and she felt it to be a right thing to kill the children before she killed herself. She says also, and this is the point to which I wish to call attention, that she lay awake the whole of the Sunday night harbouring and pondering over her intention. She says that when her husband got up in the morning he said, "How are you?" She said, "Better," in order to induce him to go to his work and leave her; and then, after her husband had gone, she committed the murder. This is the history of all the cases of this kind of which I have been able to ascertain the real facts. The acts, in the absence of delirium, or sudden provocation, are commonly premeditated, and are the result of delusion, or, what comes to be the same thing, of an insane train of thought; and these cases must, therefore, be ranked in the same category as the case of Hadfield. The poor woman, whose case is so graphically related by Lord Blackburn, was unquestionably insane, and unable to rightly estimate the moral character of her act; but we must not overlook the lesson to be learned from the fact that the act was premeditated, and that the mode in which it was to be accomplished was carefully thought out. If it were urged, in the case of this poor woman, that although she knew that she was committing a wrongful act, yet that she was unable to control her conduct, the question might well arise as to what precisely is to be understood by these words, seeing that she controlled herself during the whole of the night, and that she continued to control herself when she told her husband in the morning that she was better.

After Lord Bramwell and Lord Blackburn had given their evidence, Sir James Fitzjames Stephen was recalled; and, in the course of his re-examination, he said (Question 313), "I need not say anything of Baron Bramwell's evidence on the subject of the *principle* of the Bill, because Baron Bramwell approves. Mr. Justice Blackburn disapproves of it, upon the ground, which is very familiar to all persons who have taken much interest in discussions about codifying the law, that an uncoded state of the law is better than a codified state of the law, inasmuch as the law possesses a quality which he describes as elasticity, and which he regards as a good thing, but which I and some others should describe as uncertainty and vagueness, and regard as a bad thing."

Sir James Stephen then referred to a case, not connected with the subject of insanity, which had been discussed by him in his original examination and which had been afterwards discussed by Lord Bramwell and Lord Blackburn, and went on to say: "If I may be permitted to say so without impertinence, I suppose it would be impossible to find two higher authorities upon such a point than Baron Bramwell and Mr. Justice Blackburn, and they flatly contradict one another."

Sir James Stephen then went on to say, "Take another point. Baron Bramwell thinks that the law of England is such that insanity hardly ever, under any circumstances, excuses a man from crime; in fact, in one of his answers he goes so

far as to say that he holds the definition of insanity to be logical and correct, but does not believe that anybody ever was mad enough to fall within it. Practically, that comes to the same thing as saying that madness makes no difference as to responsibility. Mr. Justice Blackburn says, on the other hand, that the section drawn in the Bill pretty nearly represents the existing law as it is, and, if it errs, it errs in defect, because it does not take in certain cases which ought to be taken in. He adds that, in a particular case which he had to try, thinking that the existing law was, I suppose, in a very elastic condition, he took upon himself to tell the jury that there were exceptional cases which came under no rule, and that they ought to acquit the woman who was on her trial on the ground of insanity, although no authority could be found for it and although Baron Bramwell, an equal authority, considers that the woman under such circumstances ought not to be acquitted, as it was perfectly certain she was by law guilty. I do not wish to follow the matter out, because I do not wish to be considered as saying a word implying disrespect to either of those learned judges. But when you find two learned judges of the highest eminence directly contradicting each other on matters of the first importance, matters on which the life and death of persons tried before them might depend, and one of them praising that state of things as a proof of the elasticity of the common law, I can only say that I feel surprised, and cannot agree with that learned judge's praise of its elasticity. Baron Bramwell speaks quite in the opposite sense, and expresses entirely my own opinions on the matter, namely, that it is eminently desirable that you should have definitions, and that those definitions should state plainly what the law is."

The Lord Chief Justice, Sir Alexander Cockburn, was not examined by the Committee, but he submitted a written memorandum,* in the course of which he said that, although a strong supporter of codification, he objected to the Bill as being a partial and incomplete attempt at codification.

The Lord Chief Justice went on, however, to discuss the general provisions of the Bill, and, with respect to the 24th clause, made the following comment:—"As the law, as expounded by the judges in the House of Lords, now stands, it is only when mental disease produces incapacity to distinguish between right and wrong that immunity from the penal consequences of crime is admitted. The present Bill introduces a new element, the absence of the power of self-control. I concur most cordially in the proposed alteration of the law, having been always strongly of opinion that, as the pathology of insanity abundantly establishes, there are forms of mental disease in which, though the patient is quite aware he is about to do wrong, the will becomes overpowered by the force of irresistible impulse; the power of self-control when destroyed or suspended by mental disease becomes, I think, an essential element of responsibility."

In the course of his letter the Lord Chief Justice made also these further observations:—

"But there is one general provision on this subject to which I must strenuously object; it is that 'if a person is proved to have been labouring under any insane delusion at the time when he committed homicide, it shall be presumed, unless the contrary appears or is proved, that he did not possess the degree of knowledge or self-control hereinbefore specified.'

"The pathology of insanity shows that the mind may be subject to delusions which do not in any degree affect the moral sense, or the will, as regards the power of self-control. The mere existence of mental delusion ought not to affect the decision as to the power of self-control unless the nature of the delusion be such as legitimately would lead to the inference that the power of self-control was wanting. The question is one which should be decided by all the circumstances, independently of any presumption one way or the other."†

A fairly good idea may be gathered from the foregoing extracts of the difficulties that lie in the way of attempting to frame a definition of the kind and degree of insanity that should, in all cases, render a person not liable to punishment by the

* Report, page 63.

† Report, page 66.

ordinary criminal law—a definition, that is to say, that would include all cases which ought to be included, and at the same time that would not include others which ought to be excluded.

The differences of opinion between Lord Bramwell and Lord Blackburn are pointed out with sufficient emphasis by Sir James Fitzjames Stephen, but it will be observed that Sir Alexander Cockburn differed in some respects from both.

Lord Blackburn thought that “C” and “D” agreed “pretty nearly” with the answers of the judges of 1843, and that they did not go far enough to include some cases which ought to be included, whilst, on the other hand, Lord Bramwell objected strongly to both “C” and “D,” and was quite certain that they did not express the state of the existing law. Sir James Stephen, who was in favour of the adoption of both “C” and “D,” spoke of them as varying “slightly” from the answers of the judges, but as differing only by clearing up an ambiguity; whilst Sir Alexander Cockburn spoke of “D” as introducing a new element, and went on to say that he concurred “most cordially” in the proposed alteration. But he objected strenuously to the paragraph with reference to the effect of delusions.

It must not be forgotten either that, quite apart from any particular formula, differences of opinion, more or less pronounced, are by no means unknown, not only in criminal cases, but also in civil cases, in which questions relating to insanity are involved. Abundant illustration of this may be found in cases in which the question to be determined was whether the persons who were the subjects of the inquiries were or were not capable of managing themselves or their affairs, or in cases in which the question was whether certain persons who had been received for treatment in an unlicensed house were or were not insane. And then, too, with respect to criminal cases, not only do we find that honest differences of opinion arise over individual cases, but it may be observed that in the past absolute unanimity of opinion has not prevailed, even with regard to general principles; so that whilst, on the one hand, we find that great legal authorities such as Coke and Hale and Blackstone speak of the execution of a madman as being “a miserable spectacle, both against law, and of extreme inhumanity and cruelty,” we find, on the other hand, a small minority not indisposed to agree with Smollett, who, it may be remembered, was a member of the medical profession, and who yet, in the remarks which, in his *History of England*, he makes upon the case of Earl Ferrers, expresses the opinion that “Perhaps it might be no absurd or unreasonable regulation in the Legislature to divest lunatics of the privilege of insanity, and, in cases of enormity, subject them to the common penalties of the law.”—(*History of England*, by T. Smollett, M.D., 1805, Vol. v., page 208.)

As bearing upon the opinions expressed by Smollett, it is interesting to note the remarks recently made by the late Lord Chief Justice, Lord Coleridge, who, at the trial of a man named Oats at the Bodmin Assizes in February, 1891, is reported by the *Western Morning News* for February 28th of that year to have observed in his address to the Grand Jury that “It was said by a legal authority when he was a young man that if a person was found guilty of murder he should be hung, whether he was sane or not, for if he was sane he deserved it, and if he was mad it was to him no harm. That seemed to him to be a horrible doctrine, and he was glad to find it was no longer held.”

Looking broadly at the matter, however, the point which is, of all others, the most important is as to the manner in which the terms of the answers that were given by the judges in the year 1843 are now, in actual practice, construed by their successors at the present day.

We have seen how the late Mr. Justice Fitzjames Stephen held that the answers were capable of being so construed as to dispose satisfactorily of all cases whatever. But we have also seen, on the other hand, how the late Lord Bramwell considered “That although the present law lays down such a definition of madness that nobody is hardly ever really mad enough to be within it, yet it is a logical and good definition.” And that this was not a hastily-formed opinion on the part of Lord Bramwell is shown by the evidence given by his lordship, in 1865, before the Capital Punishment Commission, and also by an article contributed

by him, in 1885, to the December number of the *Nineteenth Century*, in which, it may be observed, he speaks of the law as a "right law—right to demonstration."

It will be remembered too that Sir James Fitzjames Stephen, in his *History of the Criminal Law*, expresses himself as follows:—

"What, then, is the meaning of a maniac 'labouring under such a defect of reason that he does not know that he is doing what is wrong?' It may be said that this description would apply only to a person in whom madness took the form of ignorance of the opinions of mankind in general as to the wickedness of particular crimes—murder, for instance—and such a state of mind would, I suppose, be so rare as to be practically unknown. This seems to me to be a narrow view of the subject, not supported by the language of the judges. I think that anyone would fall within the description in question who was deprived by disease affecting the mind of the power of passing a rational judgment on the moral character of the act which he meant to do. Suppose, for instance, that by reason of disease of the brain a man's mind is filled with delusions which, if true, would not justify or excuse his proposed act, but which in themselves are so wild and astonishing as to make it impossible for him to reason about them calmly, or to reason calmly on matters connected with them. Suppose, too, that the succession of insane thoughts of one kind and another is so rapid as to confuse him, and finally, suppose that his will is weakened by his disease, that he is unequal to the effort of calm sustained thought upon any subject, and especially upon subjects connected with his delusion, can he be said to know, or have a capacity of knowing, that the act which he proposes to do is wrong? I should say he could not."*

Certainly, in recent years, the manner in which juries have been directed by judges goes very far towards confirming the view of Mr. Justice Stephen, as will appear from an examination of reported cases, some of which we may now proceed to notice.

Mr. Justice Stephen, in the course of his charge to the jury at the trial, for murder, of a man named David Davies, at the Glamorganshire Spring Assizes in 1888, is reported to have expressed himself as follows (*vide the Western Mail*, March 15th, 1888): "It is said that, according to the law, a man is responsible for his acts when he knows that the act is wrong, and that is true. Now medical men frequently say that many persons who are really mad do know that the act is wrong. Now, if you will exercise your judgment in the matter, you will probably see that knowing the act is wrong means nothing more nor less than the power of thinking about it the same as a sane man would think about it."

Again, in the case of Richard Coollidge Duncan, tried at the Carnarvon Assizes in July, 1891, before Mr. Justice Lawrance, on the charge of wounding his wife with the intent to kill her, the learned Judge in his charge said:—

"The jury should consider three questions in estimating the prisoner's sanity:

"I. Did he know what were the physical consequences of his act?

"II. Did he know that it was wrong?

"III. If he knew that the act was wrong, had he sufficient strength of will to abstain from doing it?"

The jury found the accused insane.—Reported in *North Wales Chronicle*, July 18th, 1891, and *Carnarvon and Denbigh Herald*, July 17th, 1891.

Again, at the trial of a man named William Burt, at the Norwich Assizes, on the 9th of November, 1885, on a charge of feloniously causing grievous bodily harm, the report given in a local paper, the *Norfolk Chronicle*, states that Mr. Justice Stephen, having explained the state of the law as to what constituted irresponsible action, added that: "If a man were in a state of passionate rage, excited by disease, which violently interfered with his actions, so that he had not a fair capacity to weigh what he was doing, or to know that his act was wrong, he was not responsible. They had not to consider whether a man had a particular disease, but whether his conduct was, in itself, sane; and whether he acted from ordinary wicked motives, or under the influence of disease. In this case there

* *History of Criminal Law of England*, Stephen, Vol. ii., page 163.

appeared to be a mixture of motive. The prisoner was jealous, and he also suffered from epileptic fits, which produced mad, causeless violence. But, if a man acted partly from a common motive and partly from disease, he (his Lordship) suggested it was for a humane jury to give the man the benefit of the doubt, and take into consideration whether they would not have him taken care of, instead of subjecting him to punishment. If there was epileptic fury and insanity mixing with ordinary resentment and causeless jealousy, and a man acted from both motives, his lordship thought the general spirit of the law and its administration suggested that the prisoner should have the benefit of any doubt which arose."

The jury found the prisoner insane.

In the case of *Regina v. Gill*, tried at the Yorkshire Spring Assizes in 1883, before Lord Justice Kay (at that time Mr. Justice Kay), and reported in the *Leeds Mercury* of the 28th of April, 1883, the learned Judge, in charging the jury, is reported to have said that "he did not agree that to prove a man to be insane it was necessary to show that he did not know what act he was then doing, or what was right or wrong. There was another thing which might also justify a jury in finding a man insane; that was if the condition of his mind, from disease, was such that he was subject to uncontrollable impulses. If the prisoner acted under an impulse of this kind, the jury would be justified in finding him irresponsible for his act, on the ground of insanity."

In this case, however, the jury did not find the prisoner insane, but found him guilty of unlawfully wounding, and the Judge sentenced him to five years' penal servitude.

In the course of a discussion which took place in the columns of the *Times* in the autumn of 1894 a very painful case was referred to, in which a member of the bar, held in high esteem for his public and private virtues, was assassinated by one of the inmates of a lunatic asylum which he was visiting. And, in the course of some comments on that case, contained in a letter to the *Times*, dated September 4th, 1894, Sir Herbert Stephen writes:—"I think that if the coroner, magistrates, prosecuting solicitor, counsel, and judge had all been perfectly judicious and well acquainted with their legal duties, that person would have been condemned to death."

Now, with this expression of Sir Herbert Stephen's opinion, it will be interesting to compare the words of the learned Judge who tried the case, and who spoke with a full sense of the responsibility of his office, and in complete possession of all the facts. The trial took place before the Lord Chief Baron of that date—Sir Fitzroy Kelly—and, in the report of the trial given by the *Salisbury Journal* of July 26th, 1873, it is stated that the learned Judge addressed the jury as follows:—

"I do not know what inference you may draw from the evidence, but surely you are not to condemn a man to death for an act committed in a lunatic asylum, seeing that he had been an inmate of it for twenty-one years and an inmate also of another lunatic asylum for six or seven years previously, and seeing that he has suffered during all that time under chronic mania, and that a gentleman who appears as a witness for the prosecution, and who has been familiar with the prisoner's conduct and his habits and with the sad disease under which he labours, tells you his opinion is that he is not responsible for his actions. I think, whatever further evidence may be forthcoming, it will be for you to consider whether you could pronounce a verdict which would consign him to the gallows after the evidence which has been laid before you. If, on the evidence, you think he is not responsible for his actions, and that he was in an unsound state of mind on the 21st of May, it will be your duty to return a verdict of not guilty, in which case he will be kept in confinement during her Majesty's pleasure. If you desire, however, that the case should go further do not let anything that has fallen from me prevent you from hearing additional evidence."

The jury then returned a verdict, in the terms at that time, 1873, in use, of "Not guilty on the ground of insanity."

It will be observed that the Lord Chief Baron did not consider that he was in

any way hampered by any rigid formula that would be contrary to what he deemed to be right.

The following case may be cited, which was tried at Kingston, in Surrey, on the 4th of April, 1872, and was reported in the *Times* of the following day. The case was one of murder by shooting with a revolver. In charging the jury, the Lord Chief Justice (Bovill) is reported to have said:—"If anyone in his right senses kills another he is, *primâ facie*, guilty of murder. And, *primâ facie*, every person must be presumed to be in his right senses, and therefore to be responsible for his acts. But this applies only in the absence of evidence of unsoundness of mind, and there is evidence here that the mind is unsound. Then it is so difficult to trace the workings of a mind that is unsound that the presumption no longer applies; and, if the evidence satisfies you that the prisoner at the time he committed the act was not in a state to distinguish right from wrong, and was not capable of controlling his actions, then he would not be responsible for the act he committed."

The jury found the accused insane.

And, with reference to the presumption of insanity in criminal cases, the observations of Mr. Justice Denman in the case of Mr. Gilbert Scott may be cited. His lordship is reported, in the *Times* of April 8th, 1884, to have said that "a man must be taken to be sane until he is shown to be the contrary. But, if a man is proved to be insane in July, August, and September, and so on in each following month, and was then tried for murder in April, he (the learned Judge) would never tell the jury that it was necessary still to presume sanity, as though the contrary had never been shown. If insanity had been established, and had gone on for some time, then, in spite of the legal presumption, a different state of things would be raised in the minds of those who, as reasonable men, had to judge of what followed."

Other cases, such, for example, as the case of Brocklehurst, might be cited for the purpose of illustrating the manner in which the question of insanity is sometimes dealt with by judges in actual practice. Brocklehurst was tried at the Cheshire Assizes in October, 1884, before Mr. Justice Cave on a charge of feloniously wounding his wife; and a report of the trial is given in the *Macclesfield Courier and Herald* for November 1st of that year. In the course of the trial evidence was given to the effect that the accused had been an inmate of the County Lunatic Asylum from April to July, and that after his return home he began to accuse his wife of putting something into his food for the purpose of poisoning him, and that, under the influence of these and other delusions, he attacked his wife with an iron coal scraper.

He afterwards said he had done what he wanted, and that he meant to go to the gallows, indicating by that remark that he was clearly aware of the illegality of his act.

When counsel was about to address the jury on the question of the prisoner's insanity his lordship interposed with the remark that the doctor had said distinctly that the prisoner was of unsound mind. Counsel suggested, however, that the question for the jury was whether the prisoner was capable of appreciating the difference between right and wrong; but to this his lordship replied, "No; the question is whether he was insane at the time; and if a man is suffering from delusions and he attacks his wife with a scraper in consequence, it is as clear as anything can be that the man is mad." To the jury: "Do you feel any difficulty about it, gentlemen?" The Foreman: "Not the slightest." His lordship: "It is as clear as can be."

The verdict was that the accused was guilty of feloniously wounding, but that he was insane at the time of committing the act, and he was ordered to be detained during her Majesty's pleasure.

In this connection, too, we may quote Lord Campbell, who, in the discussion on McNaghten's case in the House of Lords, said (*Hansard*, 3rd series, Vol. lxxvii., p. 288 *et seq.*) "Unless it were proved that insanity existed at the time the act was committed, and that such insanity might be duly considered the immediate cause of the criminal act, there was, at present, no immunity from conviction and punishment."

From which it may be fairly assumed that Lord Campbell implied that the converse would also hold good.

It must not be overlooked that, somewhat more than ten years ago, certain amendments, not only in the statutes but also in procedure, were introduced which have not been without effect.

Thus, in the year 1883, an Act was passed entitled the "Trial of Lunatics Act" (46 and 47 Vict., cap. 38), by which, as has been already pointed out at the beginning of this memorandum, the first section of the Act of 1800 was repealed, and other different provisions were made.

A further step was taken in the following year, when some of the statutes relating to Criminal Lunatics were consolidated and revised by the "Criminal Lunatics Act, 1884" (47 and 48 Vict., cap. 64).

In addition to sundry other amendments this Act contains provisions by which the Secretary of State is empowered to attach to the discharge of a criminal lunatic whatever conditions he may think fit; and, further, to order the return into custody of a person so discharged in the event of any of the conditions being broken, or if it should appear that such person had, from any cause, become unfit to remain at large; and thus, in the case of every person who may be found by the jury at his trial to have been guilty of the offence charged against him and yet to have been insane, every care is taken to afford protection against the commission of any further injury by the same person; whilst provision is made by which the accused not only at once receives such care and treatment as his insane condition may require, but by which it is also ensured that his detention and the deprivation of liberty shall not be continued longer than actually necessary in the interests of public safety.

The "Criminal Lunatics Act" also prescribes the manner and the circumstances under which persons may be removed from prisons to asylums on the ground of insanity, either whilst awaiting trial or at a later stage. It will be observed that for the purpose of such removal, not only are the certificates of two medical practitioners and of two members of the Visiting Committee of the prison required, but the approval of the Secretary of State is also necessary. And it will be further observed that in the case of a prisoner under sentence of death there is an additional precaution. In other cases the members of the Visiting Committee "call to their assistance two legally qualified medical practitioners;" but in the case of a prisoner under sentence of death the two medical practitioners are specially appointed by the Secretary of State himself.

With reference to the medical staff of the prisons, it is very satisfactory to observe that the recent Departmental Committee recommend, amongst other things, in their Report, presented to both Houses of Parliament in April, 1895, that candidates for medical appointments in prisons should be required to show that they have given special attention to lunacy; and, also, that weakminded prisoners should be concentrated, as far as possible, in special prisons, and should be under special medical supervision.

It is further to be observed that in the same year in which the "Criminal Lunatics Act" was passed, that is to say in the year 1884, a very important amendment was also introduced into the procedure, in laying evidence before the jury, in those cases in which the accused is alleged, or is believed, to be insane. This amended procedure was explained, in the House of Commons, by the Attorney-General of that day, Sir Henry James (now Lord James of Hereford), on March 17th, 1884, of which a report is given in *Hansard*, 3rd series, Vol. cclxxxvi., page 40. In the course of his remarks Lord James said, "Perhaps it will be the better course for me, in answer to the question of my honourable friend, to state what directions I have given to the Director of Public Prosecutions. I lately received a communication from the Home Office to the effect that, in some recent cases, great inconvenience, if not injustice, had resulted from no responsible person being in charge of cases when the life of the accused was at stake. I was also informed that the Home Office had found great difficulty in dealing with cases of alleged insanity, in consequence of the facts not being brought before the jury, and being only suggested after the trial. It seemed to me, therefore, advisable to take steps to ensure that all evidence bearing on the case, whether tending to

prove the guilt or the innocence of the prisoner, should be placed before the jury and, with that object, I have requested that, whenever an accused person is brought before justices on a capital charge, the magistrates' clerk shall communicate with the Solicitor of the Treasury, and that that officer shall take charge of the prosecution, unless he finds that some competent private person or local body has the conduct of it; but, in the absence of such proper conduct, it will be the duty of the Treasury Solicitor, acting as the Director of Public Prosecutions, to see that the evidence in every capital case is brought fully before the jury. I have also requested that, in those cases where insanity in the accused is alleged, full inquiry shall be made, and, in the absence of his ability, or of the ability of his friends, to produce witnesses, the Treasury Solicitor shall secure their attendance.

With reference to the foregoing statement of the Attorney-General, it will be observed that, at the date when that statement was made, in March, 1884, the Solicitor of the Treasury is referred to as an officer who, at that time, *acted* as the Director of Public Prosecutions. In the month of August, however, of that year, an Act was passed (47 and 48 Vict. cap. 58), by which the Treasury Solicitor *became* actually the Public Prosecutor. The exact words of the Act are "the person for the time holding the office of Solicitor for the affairs of Her Majesty's Treasury shall be Director of Public Prosecutions."

In giving effect to the instructions, that in those cases where insanity is alleged "full inquiry shall be made" it is now the practice of the Public Prosecutor, in cases of the kind, to make application to independent medical men and to request them, if they are willing so to do, to examine the accused before the trial, and to draw up a report as to the mental condition of the accused, for the information of counsel and of the Court. But this action on the part of the Public Prosecutor does not in any way prevent the accused from bringing forward whatever additional evidence he or his advisers may think desirable.

The object of the Public Prosecutor is to obtain, if possible, an absolutely impartial opinion, and then, at the trial, to lay that opinion, together with all the facts of the case, so far as they can be ascertained, fully and completely before the Court.

What, then, it may be asked, are the actual results? And to this question an answer may be found in the Annual Reports of the Public Prosecutor.

In the Return relating to the Prosecution of Offences Acts, ordered by the House of Commons to be printed, on the 7th of April, 1893 (No. 162), the Public Prosecutor reports, at page 16, that all charges of murder are, and that most charges of manslaughter and of other serious offences against the person are, or ought to be, brought to his notice, so that he may exercise the discretion imposed upon him with reference to this class of indictable offences. And then he goes on to give the following statistics. The number of cases of capital offences brought to his notice in the three years 1890, 1891, and 1892 was 209, the disposal of which was as follows:—

Verdicts of wilful murder returned, and sentences of death passed ...	...	55
Found to be insane ... ..	...	51
Verdicts of not guilty ... ..	...	40
Found guilty of manslaughter or of some crime less than murder ...	...	63

Total 209

The foregoing figures, which, it may be observed, refer only to England and Wales, show that whilst, in the three years under review, the number of persons, charged with capital offences, who were sentenced to death, was 55, the number charged with capital offences, who were found to be insane, was 51, a number not much less than the number of those who were sentenced to death. And with these figures before us it is clear that, in actual practice, the law is not now interpreted in the manner in which Lord Bramwell understood it when he said that "the present law lays down such a definition of madness that nobody is hardly ever really mad enough to be within it." On the contrary the figures which have been quoted would appear to show that the interpretation placed by

judges at the present time upon the language of their predecessors is such as to attain the result which Sir James Fitzjames Stephen indicated, and, virtually, "to dispose satisfactorily of all cases whatever."

Having reached this point, it may be useful to ask ourselves these questions:—

I. Is it the fact that all cases are, at the present time, satisfactorily disposed of?

II. If it is not the fact, would not our right course be to draw up a list of recent cases which are considered to have not been satisfactorily disposed of, and then to endeavour to ascertain whether, in each case, such failure has been due, (a) to the terms of the answers given by the judges in 1843, or (b) to some other cause?

III. Another question that might perhaps arise is, whether a case can be said to have been "satisfactorily" disposed of if such case has been decided in a manner which would appear not to be in absolutely strict conformity with what, by some commentators, has been regarded as the precise meaning of the terms employed by the judges in the year 1843?

But, with respect to this point, it may perhaps be permissible to suggest that the answers given by the judges, in 1843, were given by them for the use of other succeeding judges; and that, if the present distinguished occupants of the bench are able to perceive the possibility of placing upon the terms of those answers an interpretation capable of disposing satisfactorily of every case, it would hardly appear to be for us to attempt to call in question their right so to do.

MURDER BY A PATIENT IN THE DUNDEE ASYLUM.

The Dundee Royal Asylum was recently the scene of a murder by a patient named Redmond, who while at work in the grounds suddenly attacked an attendant with a spade, inflicting serious injuries, and killing outright a fellow patient who came to the rescue. A brother of this patient is reported to have committed homicide. This would appear to be one of those regrettable incidents which constitute the penalty for the innumerable advantages resulting from the modern system of employment of the insane; calling not only for sympathy with the sufferers, but also with the physicians under whose supervision they happen.

PRINCELY HEREDITARY MENTAL DEGENERACY AND MONOMANIA.

Prince Charles de Loos Corswarem was tried before the Correctional Tribunal of Brussels, in February, on charges of swindling and forgery extending over several years. He had obtained "millions of francs" from usurers and others raised on the dowries of ladies whom he was about to marry. He was acquitted, firstly, because he was irresponsible, and secondly, because the charges were not proven. This form of insanity would appear to be associated with a large amount of method.

THE INSANITY LAW.

The Legislature of New York State is proceeding to codify the laws relating to insanity, and the *Medical Record* (7th March, 1896), while justly urging the increase of the Lunacy Commission to eleven members, denounces the provision which is proposed that the medical member "shall have had five years' actual experience in the care and treatment of the insane, and is, or has been a Superintendent or first Assistant Physician of a State Hospital."

The *Record* goes on to recommend that the appointment should be filled by a practitioner experienced in the field of neurology, since "no one trained in asylum methods could detect the errors in the treatment of the insane in these institutions." In other words the view of the *Record* seems to be that the less a man knows about insanity the better qualified he is to act as a Medical Commissioner. In this view, the writer of the *Record* article should be an eligible candidate, but perhaps he is not a neurologist.

CORK ASYLUM.

In view of the overcrowding in this institution for some time past, the Board of Governors has adopted a suggestion that a hospital should be built on grounds adjoining the asylum, which should be a complete establishment in itself, and to which all curable cases should be removed. We congratulate the Board on their decision.

WOODILEE ASYLUM.

An action, brought by the Barony Parish of Glasgow *v.* the General Board of Lunacy, contended that Woodilee was a Public or Parochial Asylum, and that in either case a license from the General Board was not required, nor that the Board were not entitled as a condition of license to prescribe the number of the Managing Committee. Lord Low, before whom the action was brought on appeal, decided in favour of the Barony Parish.

THE DUXHURST HOSPITAL HOME FOR LADY INEBRIATES.

This home, The Manor House, Duxhurst, near Reigate, has been recently opened under the auspices of Lady Henry Somerset, for the treatment of ladies suffering from alcoholism or narcotism.

The house, formerly a gentleman's residence, is admirably adapted for its present use, surrounded by extensive gardens, grounds, and farm, with fine views and in good air, between three and four miles from Reigate. It is thoroughly in the country, the nearest beerseller being a mile and a half distant. The water supply is good and the drainage has been arranged by Mr. Rogers Field.

In addition to the usual means of recreation, special provision has been made by the engagement of a trained lady gardener, to give gardening occupation, not only out of doors, but also in extensive glass houses which have been erected to this end. This is evidently a most valuable adjunct to the treatment.

The terms vary from two to five guineas.

Having inspected the home, we have formed a very favourable estimate of its advantages, and heartily wish success to so charitable an undertaking.

At a second home at some little distance on the same estate, patients of a less educated class are received at a lower rate, the maximum being thirty shillings per week.

A third establishment, also at a convenient distance, receives habitual inebriates of a still lower class, who have been imprisoned, etc.

These are accommodated in six prettily constructed cottages specially built for the purpose; each cottage receives six patients under the care of a nurse, and there is a central building for the kitchen, dining hall, and recreation room. The whole constitutes one of the best arrangements for the management and treatment of this class of invalids that has been established in this country.

THE MORISON LECTURES.

The Morison lectures for the present year have been delivered by Dr. Alexander Bruce, who has chosen for his subject "The Nerve Tracts and Connections of the Special Nerves in the Spinal Cord, Mid and Hind Brain."

The publication of these lectures will be awaited with interest by all who have not had the good fortune to attend their delivery.

LUNACY COMMISSION IN IRELAND.

The following gentlemen now serve as Commissioners for general control and correspondence, and for the superintending and directing the erection, establishment, and regulation of asylums for the pauper lunatics of Ireland:—The Rt. Hon. Mr. Justice Holmes, Mr. Thomas Robertson, Dr. O'Farrell, Dr. Courtenay, F. R. Cruise, M.D., Mr. David Drummond, and Mr. Charles Kennedy. It will be observed that the retirement of General Sir R. H. Sankey, R.E., from the chair-

manship of the Board of Public Works has been followed by the appointment of Mr. Robertson, who succeeds him in that office as well as on the Board of Control.

DR. NICOLSON.

We have pleasure in recording the presentation to Dr. Nicolson, by the officers and staff of the Broadmoor Asylum, of a silver bowl, with appropriate inscription, on the occasion of his resigning his post at that asylum.

OBITUARY.

DR. SEMAL.

We regret to have to record the death of Dr. François Joseph Semal, physician and director of the great asylum at Mons, on the 16th May. We hope to give an account of Dr. Semal's life and work in the next number of the Journal.

PARLIAMENTARY INTELLIGENCE.

Alleged Increase of Insanity.

Mr. Corbet has given notice of a resolution that "it is desirable that an International Commission be convoked to inquire into this matter."

Sir M. W. Ridley, in answer to a question by Mr. Hobhouse, said that "he had suggested to the Lord Chancellor" that the Lunacy Commissioners should "make special inquiries as to the causes of the increase of lunacy, and embody their conclusions in the next annual report."

Private Lunatic Asylums.

Mr. Corbet (21st February, 1896) asked whether, in view of the recent case in which a sane lady was shut up in a private asylum, the Home Secretary would take any steps for their abolition? The latter, in answer, said that the Lord Chancellor had a Bill in preparation which, among other things, aimed at the improving and extending the precautions against any abuse of the Lunacy Laws.

Irish Pauper Lunatics.

The Poor Relief Bill for Ireland, the Chief Secretary states (24th April), will deal with the detention of lunatics in workhouses.

Deportation of Paupers.

In answer to questions referring to the removal of a pauper from Eltham, in Kent, to Dublin, and of a lunatic pauper from Glasgow to Banbridge, in Ireland, the Chief Secretary said "that that was the subject of communication between the authorities in England, Ireland, and Scotland."

Suicides at Sea.

Mr. Akers Douglas (23rd April) stated, "That the attention of the Board of Trade had been called to the large number of suicides among firemen and trimmers in the mercantile marine, and that further information was being collected."

Habitual Drunkards.

Sir M. W. Ridley (24th February, 1896), in answer to a question by Mr. Pease, said that "a measure for the treatment of this one class of offenders is in preparation, and will shortly, I hope, be introduced."

On April 16th he said, "The Bill is in draft . . . but the details, especially from a financial point of view, require the most careful consideration. . . . I cannot say when I shall be able to introduce it."

Sir M. W. Ridley has also said that the Bill would be founded on the recommendations of the English Departmental Committee on Inebriates.

Evidence in Criminal Cases Bill.

This Bill was introduced by the Lord Chancellor, and has passed its third reading in the House of Lords.

It proposes to enact that "a person charged with an offence, and wife or husband, become competent witnesses."

The person charged with an offence on giving evidence is not to be cross-examined as to character.

NOTICES BY THE REGISTRAR.

Examination for the Certificate of Proficiency in Nursing.

Applications were received from 491 candidates for admission to the recent examination. These were drawn from 27 English, nine Irish, and seven Scotch Asylums. The returns show that of this number 397 were successful, 86 failed to satisfy the Examiners, and eight withdrew. The following is a list of successful candidates :—

(The letters *C*, *S*, and *W* indicate respectively the number of candidates who entered for the examination, who were successful, or who, for any reason, withdrew.)

Durham County Asylum, Winterton (*C*, 21; *S*, 15; *W*, 0).—*Males*: Thomas S. Bellas, Frederick Hewston, Robert Alexander Larkin, Arthur Mitchell, William T. Wailes. Thomas L. Walker. *Females*: Jennie Applegarth, Charlotte Balshaw, Arabella Berryman, Sarah E. Foster, Annie Jackson, Emma Maughan, Hannah Maughan, Ellen L. Masters, Annie E. Smith.

Kent County Asylum, Chartham (*C*, 3; *S*, 3; *W*, 0).—*Males*: George Barnes, William Henry Hucks, John D. Stott.

London County Asylum, Claybury (*C*, 49; *S*, 37; *W*, 2).—*Females*: Annie Brews, Amy Brooks, Catherine Cleary, Minnie L. Cornwall, Maude Cooper, Rose Chivers, Mary Coughlin, Lucy Clark, Hannah French, Emma French, Emma L. Goodwin, Rosina Golden, Florence Hiscox, Alice Hoffman, Jennie Hughes, Katherine Jones, Florence S. Johnson, Annie Kidd, Gertrude E. Lane, Mary Lord, Lottie Lucas, Frances B. Melbourne, Beatrice Matthews, Ada M. G. Missenden, Elizabeth A. Nash, Annie Price, Annie Pashley, Bessie Perrin, Emily Jane Smith, Annie Smallbone, Harriet E. Thorogood, Sissie Voisey, Alice Williams, Ellen Winstanley, Sarah J. Withers, Sarah Wood, Fredericka Werry.

Lancashire County Asylum, Rainhill (*C*, 26; *S*, 13; *W*, 3).—*Males*: William Ashworth, Arthur Harvey, Arthur John Hanrahan, William McBain, Percy Smith. *Females*: Susannah Balls, Annie G. Baxter, Mary E. Currie, Mary E. Denton, Therese Daly, Clara Fryer, Clara Molyneux, Margaret Parker.

Oxford County Asylum, Littlemore (*C*, 11; *S*, 11; *W*, 0).—*Males*: Joseph Challis, Francis Costar, Frank E. Truss, Thomas Wyatt. *Females*: Jane Bonham, Emma Eeles, Clara Gentle, Annie E. Golding, Rose M. Titcombe, Florence M. Tompkins, Sarah Webster.

Surrey County Asylum, Brookwood (*C*, 15; *S*, 14; *W*, 1).—*Males*: Henry Albert Collyer, Henry Field, James Gaynor, James Rendell, Thomas J. Sharp, Edward Trask, Alfred G. Twissell. *Females*: Gladys Anderson, Annie Baker, Emma Haynes, Edith Newell, Minnie Robinson, Mabel A. Thomas, Nellie Elizabeth Timms.

Stafford County Asylum, Burntwood (*C*, 13; *S*, 9; *W*, 0).—*Males*: Thomas Eel, Frank Roberts, Jacob Southgate. *Females*: Barbara Brown, Jane Ann Gair, Annie Stokes, Annie Turnham, Mary Ward, Annie Wells.

Warwick County Asylum, Hatton (*C*, 19; *S*, 17; *W*, 0).—*Females*: Sarah Ann Bullas, Sarah Ann Brookes, Maud Edge, Clara Flavell, Elizabeth Girling, Elizabeth Hydon, Ellen Hextall, Sarah Hextall, Rose Jones, Penelope Kemp, Ellen Kimber, Martha Lord, Edith Mitchell, Lizzie Sutton, Ellen Skelcher, Harriet Tarver, Annie Maria Wilkins.

West Riding Asylum, Menston (C, 12; S, 11; W, 0).—*Males*: John Kerry, Guido Milladew, Joseph Swift, Elijah Weeks. *Females*: Clara Bull, Henrietta Denning, Hannah Jeffrey, Ellen Kaye, Maude Ramsden, Annie Swift, Mary Isabel Wildsmith.

West Riding Asylum, Wadsley (C, 11; S, 8; W, 0).—*Males*: Charles Jas. Bacon, William H. Crowe, Henry E. Dodd. *Females*: Emily Beasley, Annie L. Hartley, Helena M. Robinson, Harriet Smith, Elizabeth Willis.

West Riding Asylum, Wakefield (C, 6; S, 4; W, 0).—*Males*: John D. Hutchinson, Peter Haddow, John Robinson. *Female*: Alice Cowell.

Glamorgan County Asylum, Bridgend (C, 36; S, 26; W, 0).—*Males*: William N. Cook, Fred. Duke, William Davies, John Earl, Bernard Evans, Thomas Green, John Jones, Hugh L. Jenkins, John W. Missenden, Arthur B. Pearson, Albert P. Potter, Francis Rawle, John Whittall, Thomas Westcott. *Females*: Gwenllian Evans, Elizabeth Evans, Annie Golledge, Emma A. Griffiths, Sarah J. John, Elizabeth Lewis, Annie M. Perkins, Sarah A. Poole, Elizabeth M. Potter, Mary J. Turner, Violet E. Warr, Margaret Williams.

Joint Counties Asylum, Carmarthen (C, 11; S, 9; W, 0).—*Males*: James Clarke, William Evans, Joshua Harris, William Lodwick, John Thomas. *Females*: Margaret A. Bowen, Margaret A. Jones, Emeline L. Nutman, Annie Thomas.

City Asylum, Bristol (C, 14; S, 13; W, 0).—*Males*: George H. Serles, Samuel G. Steele, Henry G. White, Thomas R. B. Walker. *Females*: Amelia R. Button, Annie E. Bradley, Elizabeth A. Freebury, Mary J. Howes, Mary McGuinness, Florence E. M. Pope, Eliza J. Thatcher, Emily L. K. Whale, Minnie Wilson.

City of London Asylum, Stone (C, 3; S, 3; W, 0).—*Males*: Benjamin Goodwin, James A. Penfold, Arthur L. Rogers.

Borough Asylum, Hull (C, 12; S, 10; W, 0).—*Males*: William Q. Boulton, John Beaulah, John Moody, William Pattison, John Robinson, John Whitehouse. *Females*: Louisa Bullough, Mary A. Bailey, Elizabeth M. Cranswick, Emmie Taylor.

Borough Asylum, Derby (C, 12; S, 12; W, 0).—*Males*: Henry Gilbert, Joseph Lewis, Norman Macdonald, Norman McIsaac, William McSparran. *Females*: Gertrude M. Alcock, Elizabeth Entwistle, Clara Foster, Lizzie Gaunt, Edith A. Sayers, Christina Mackenzie, Susan Wright.

Borough Asylum, Nottingham (C, 6; S, 6; W, 0).—*Males*: James Harrison, James Preston, Mark Reynard, Frederick Rose. *Females*: Mary Ann Cobley, Elizabeth Wood.

Borough Asylum, Plymouth (C, 6; S, 6; W, 0).—*Males*: Arthur Elford, Alfred Harpham, William James Rich. *Females*: Annie Stone, Annie Treleaven, Cordelia Wells.

Holloway Sanatorium, Virginia Water (C, 26; S, 24; W, 1).—*Males*: Louis J. Durrant, George Hobbs, Edward Hardy, Herbert H. Hartley, Harry G. Kyte, George North, Edward Northern, John Souttar, George F. Grey-Smith, Thomas Wells. *Females*: Ethelwyn M. Amore, Hannah L. A. Bray, Annie Baker, Matilda Francis, Louisa M. Fowle, Bertha Foster, Alice Frost, Alice H. L. Lake, Helen Pain, Amy E. K. Shanks, Emma Sheldon, Rosa M. Trigg, Charlotte M. Triphook, Amy Hay-Thomson.

Coton Hill Asylum, Stafford (C, 4; S, 2; W, 1).—*Males*: Charles Hayward, Edward Harry Reeder.

The Retreat, York (C, 4; S, 3; W, 0).—*Males*: John Wilson, John Frederick Simpson. *Female*: Mary Susannah Clark.

Ashwood House Asylum, Kingswinford (C, 2; S, 2; W, 0).—*Males*: Edwin Carpenter, William Moody.

Hoxton House Asylum, London (C, 9; S, 8; W, 0).—*Males*: William Henry Darville, James B. McDermott, William C. Sweetnam, Henry S. Watts. *Females*: Elizabeth Kitchener, Lilian Melross, Elizabeth Reith, Frances Ashe.

Northumberland House Asylum, London (C, 4; S, 4; W, 0).—*Females*: Frances L. Brown, Agnes Smith, Mary A. Taylor, Margaret M. Walsh.

State Asylum, Broadmoor (C, 8 ; S, 5 ; W, 0).—*Females* : Marion Hughes, Annie Schofield, Elizabeth Mears, Susannah Blackman, Florence L. Scott.

The Royal Asylum, Montrose (C, 16 ; S, 13 ; W, 0).—*Males* : William Brown, William Clark, David Dorward, John Keith, Charles McDonald, Alexander Milne, Marinus S. Ross, John Couatts Thomson. *Females* : Margaret Beattie, Catherine Cooper, Isabella Findlay, Mollison Law, Margaret Low.

James Murray's Royal Asylum, Perth (C, 5 ; S, 5 ; W, 0).—*Females* : Jane E. Goulbourn, Annie Low, Barbara Pirie, Nellie G. Smith, Annie M. Urquhart.

Glasgow District Asylum, Kirklands (C, 3 ; S, 3 ; W, 0).—*Male* : Alexander G. Mess. *Females* : Barbara Frood, Charlotte Glass.

Fife District Asylum, Cupar (C, 6 ; S, 6 ; W, 0).—*Males* : William Morton, William Swinton, Robert Splitt. *Females* : Kate J. Kirkcaldy, Maggie Ross, Jessie Urquhart.

Perth District Asylum, Murthly (C, 6 ; S, 5 ; W, 0).—*Males* : Peter Keay, David Player, James Peter, William Sinclair. *Female* : Jane Urquhart.

Roxburgh District Asylum, Melrose (C, 4 ; S, 4 ; W, 0).—*Males* : Robert Kerr, Robert Christie, William Sandieson. *Female* : Alice Simson.

Stirling District Asylum, Larbert (C, 2 ; S, 2 ; W, 0).—*Male* : David Shepherd. *Female* : Catherine McLeish.

Smithson Asylum, Greenock (C, 3 ; S, 3 ; W, 0).—*Males* : Alexander Biddie, Malcolm Nicolson, James Myron.

District Asylum, Cork (C, 8 ; S, 5 ; W, 0).—*Males* : Cornelius Murray, John Murphy. *Females* : Mary Hanlon, Katie Lehane, Mary McCarthy.

District Asylum, Clonmel (C, 14 ; S, 5 ; W, 0).—*Males* : Terence B. Kelly, Michael Norris. *Females* : Mary Aylward, Bridget Lonergan, Kate Walsh.

Richmond Asylum, Dublin (C, 25 ; S, 20 ; W, 0).—*Males* : Patrick Baker, James Brennan, John Greham, Joseph McQuaid, Robert Shore, Charles Travers, Michael Staunton. *Females* : Kate Coleman, Jane E. Hughes, Bridget A. Hogan, Mary Hatton, Lizzie Keenan, Kate Murphy, Nora Maher, Rachel O'Brien, Kate Reddy, Esther Rourke, Anne Smyth, Esther Wilson, Mary Anne Wilson.

District Asylum, Kilkenny (C, 6 ; S, 6 ; W, 0).—*Males* : Michael Dowling, Matthew Holohan, Thomas Hennessy, senior, Thomas Hennessy, junior, John Menton, Martin Murray.

District Asylum, Limerick (C, 11 ; S, 6 ; W, 0).—*Males* : Andrew Creagh, Patrick Flynn, Denis Sullivan. *Females* : Mary A. McInerney, Ellen O'Brien, Margaret Wade.

District Asylum, Londonderry (C, 6 ; S, 6 ; W, 0).—*Males* : Daniel Moran, John McCool. *Females* : Isabella C. Caldwell, Sarah Doherty, Catherine Gallagher, Grace McFadden.

District Asylum, Mullingar (C, 14 ; S, 14 ; W, 0).—*Males* : Laurence Boyhan, Thomas Conroy, Thomas Colclough, Patrick Creevy, William Gilliam, William Hynes, George Owens. *Females* : Bridget Allen, Anne Beglin, Lizzie Callaghan, Bridget Fox, Teresa Harford, Maria McLoughlin, Ellie McLoughlin.

District Asylum, Maryborough (C, 18 ; S, 18 ; W, 0).—*Males* : Murtha Corcoran, Daniel Carroll, William Grant, Harry W. Inglis, Joseph Scully, John Scully, William Scully, Richard Lynch. *Females* : Lizzie McDonald, Mary A. Dunne, Charlotte Flynn, Theresa Grant, Kate Hiney, Mary A. Keating, Kate Long, Sarah Lynch, Anne Scully, Margaret Wallace.

Hampstead House Asylum, Dublin (C, 1 ; S, 1 ; W, 0).—*Male* : Samuel Boyd.

The following is a list of the questions which appeared on the paper :—

1. Mention and describe the kinds of joints, and give examples.
2. What is a varicose vein ? How is it produced, and what dangers may it give rise to ?
3. What is sleep ? How do you explain it physiologically ? How is it encouraged, and how disturbed ?
4. In what kind of cases is homicidal tendency most frequently met with, and explain why ?

5. Define an illusion, a delusion, and an hallucination: give examples of each. What are their respective values in mental disease?
6. What general instructions should be attended to in the feeding of the sick?
7. What are the chief points to be observed in the management and condition of a sick room?
8. What are the occurrences which call for immediate and special report on the part of Attendants and Nurses?
9. What dangers and risks are persons suffering from General Paralysis liable to?
10. How would you act in a case of choking, and in what class of cases is choking most likely to occur?

The next examination will be held on Monday, the 2nd day of November, 1896, and candidates are earnestly requested to send in their schedules, duly filled up, to the Registrar of the Association, not later than Monday, October 5th, 1896, as this is the last day upon which, under the rules, applications for examination can be received.

For further particulars respecting this and the other examinations of the Association apply to the Registrar, Dr. Spence, Burntwood Asylum, near Lichfield.

CERTIFICATE IN PSYCHOLOGICAL MEDICINE.

The next Examination for the Certificate in Psychological Medicine will be held on Thursday, July 16th, 1896, at 10 o'clock a.m., in London at Bethlem Hospital; in Edinburgh at the Royal Asylum, Morningside; in Glasgow at the Royal Asylum, Gartnavel; in Aberdeen at the Royal Asylum, Aberdeen; and in Dublin at the Richmond Asylum, Grangegorman. Applications for admission to the Examination should be sent not later than Thursday, July 2nd, 1896, to the Registrar, who will be happy to supply any further information on this subject.

GASKELL PRIZE.

The Examination for this prize will be held at Bethlem Hospital in July. All particulars can be obtained of the Registrar.

NOTICES OF MEETINGS.

NEXT MEETING OF THE ASSOCIATION.

The Annual Meeting will be held in the Rooms of the Association, 11, Chandos Street, Cavendish Square, on July 23rd and 24th, and there may possibly be an excursion on Saturday, the 25th.

The following subjects have been suggested:—Heredity in Mental Disease; Nomenclature of Mental Disease; Brain Changes in relation to Mental Symptoms; Treatment of any form of Mental Disease (selected by the contributor).

BRITISH MEDICAL ASSOCIATION.

The sixty-fourth Annual Meeting will be held at Carlisle, July 28th, 29th, 30th, and 31st, 1896.

Section E.—Psychology.

President—JOHN ARCHIBALD CAMPBELL, M.D., F.R.S.E.

The President will open the Section with an Address. Discussions have been arranged on the following subjects:—I. The Certification of Insanity; in its relation to the Medical Profession. II. The General Paralytic: His Practical Management and Treatment in Asylums. III. The use of Sedatives and Hypnotics in the Treatment of Insanity. Papers are invited on:—I. The

"Hospital" Treatment of the Insane in Asylums. II. The best methods of providing for the Chronic Incurable among the Pauper Insane. III. The Treatment of Insanity by means of Thyroid and other Animal Extracts. IV. The Transmission of accidentally-acquired forms of Insanity.

CONGRESS AT NANCY.

As previously announced the seventh Annual Congress of Alienists and Neurologists will be held at Nancy on 1st August, 1896.

CONGRESS AT MUNICH.

As previously announced, the third International Congress of Psychology will be held at Munich, 4th August, 1896.

CONGRESS AT GENEVA.

The fourth International Congress of Criminal Anthropology will be held at Geneva from the 24th to the 29th August next. The British members of the International Committee are Dr. Buchanan (Bengal Central Gaol), Dr. Clouston, Havelock Ellis, Francis Galton, Dr. Garson, Bevan Lewis, Dr. Maudsley, Douglas Morrison, and Dr. Nicolson. The organisers, for the first time in these Congresses, have been at some pains to secure British co-operation, and it is to be hoped that their efforts will be successful. Dr. Ladame (the President of the Committee), at Geneva, will be pleased to receive the names of those who propose to be present. The subscription, entitling to the preliminary reports and to the subsequent volume of Proceedings, is fixed at 20 francs. The papers and discussions at present on the programme include "The Positive Facts Demonstrating the Born Criminal" (introduced by Morselli), "Sexual Perversion from the Point of View of Criminality" (Garnier), "Sexual Inversion" (Magitot), "Professional Criminality" (Tarde), "Relation of Criminal Statistics to Professional Statistics" (Kurella), "The Results of Ancestral Alcoholism (Legrain), "Youthful Offenders" (Roussel), "Unrecognised Insanity and the Need for More Frequent Medical Intervention" (Garnier), "Criminal Suggestion" (Bérillon), "The Diagnosis of 'Moral Insanity'" (Benedikt), "The Treatment of Criminals" (Lombroso and Brockway), "The Classification of Criminals" (Garofalo), "The Teaching of Criminal Anthropology" (Lacassagne), "The Brain Cortex in Criminals and Epileptics" (Roncoroni), and many other papers of interest and importance by Motet, Sighele, Galton, Näcke, Ferri, Mendel, Ballet, Drill, Manouvrier, Aubry, Van Hamel, etc.

APPOINTMENTS.

RICHARD BRAYN, Esq., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A. Assoc., King's Coll., Lond., has been appointed Medical Superintendent to Broadmoor Criminal Lunatic Asylum, in place of Dr. Nicolson, resigned.

MR. JOHN ALFRED EWAN, M.A., M.D., C.M.Edin. (Senior Assistant Medical Officer Dorset County Asylum), has been appointed Medical Superintendent to the Kesteven and Grantham District Asylum.

MR. HAROLD ANDREW KIDD, M.R.C.S.Eng., L.R.C.P.Lond., Senior Assistant Medical Officer Cane Hill Asylum, has been appointed Medical Superintendent to West Sussex Asylum.

CHARLES MACPHERSON, M.D., L.R.C.S.E., D.P.H., appointed Deputy Commissioner in Lunacy for Scotland, vice Dr. Lawson, deceased.

MR. C. S. MORRISON, L.R.C.P., L.R.C.S.Eng., L.F.P.S.Glasg., has been appointed Medical Superintendent of the County and City Asylum, Hereford, vice T. A. Chapman, retired.

DR. SAVAGE has been appointed Physician for Mental Diseases to Guy's Hospital.

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VOL. XLII.

PART I.—ORIGINAL ARTICLES.

*Presidential Address delivered at the Fifty-fifth Annual Meeting
of the Medico-Psychological Association, held in London,
23rd and 24th July, 1896. By W. JULIUS MICKLE, M.D.,
F.R.C.P. (London), President.*

MENTAL BESETMENTS.

Mental besetments or obsessions will be considered in their general aspects, position, and relations. It is not intended to make elaborate clinical description of their various forms. To systemise, and to make the scope of what follows clear at a glance, the subject will be divided under several heads:—

1. A slight outline of besetments of mind or obsessions will be drawn.

2. Their psychological and clinical position will be briefly examined in the division of them by the writer.

3. Next their general characters will be noticed, and

4. Fourthly, the necessity of extricating them, by differential distinction, from conditions with which they have been confounded.

5. Together we take (a) their gradual development in some cases into special mental disturbance, and even into actual insanity; and (b) their desperately dangerous and injurious type in some examples, and the graded scale between these and the trivial.

6. Their relation to phenomena in primitive man, and in savages, and to conditions in ordinary forms of paranoia.

7. Their nosological position, alliances, and congeners.

8. Cases illustrating several of the foregoing departments of the study of besetment.

9. The clinical aspects of obsessions in their several degrees. And instead of giving a long clinical account of

the many forms of obsession I will end by reproducing a description—written, apparently, in the mental life-blood of the sufferer, a master of English—the earliest full description, and the best one that has yet appeared of certain forms of obsession.

Space fails for discussion and complete delineation of all mental besetments, or even of those not within the limits of the one reproduced.

I.

A BRIEF OUTLINE OF OBSESSIONS OR BESETMENTS.

Mental obsession, or the state in which the mind is affected by some compulsive thought, of a kind, or irrational and often progressive fear; alone, or conjoined with an impulse which is, or tends to become, irresistible. Also an abulic form.

In the more severe forms the fundamental condition is anxious pathological obsession, which oppresses and tortures its victims the more they struggle against it. He suffers from morbid besetment who is obliged to count all the gas-jets, or all the trees, on his way, and who, making a mistake or becoming confused and forgetful in the reckoning, falls into a state of anguish, which is only relieved by retracing his steps and recommencing the enumeration; or he who is besieged by an evil, or absurd, or foul word or phrase ever rising to the lips, and is thrown into anxious tumult by the struggle to avoid expression of it, but fails to recover momentary ease except at the price of uttering it, if only in a whisper. And much the same applies to those who are apt to be troubled, and their consciousness occupied, with an unceasing train of questionings or metaphysical problems, *e.g.*, on God—the world—the future—perhaps until they doubt their own existence—or with a series of questions, like an endless screw, on some trivial, trumpery, or absurd irrelevant topic; or who cannot approach a window without the impulse to precipitate themselves; or who cannot be near certain classes of persons, or near brittle objects, without an impulse to strike the former or break the latter; or who if walking the pavement must pick their steps under compulsion of the conception of a precise and necessary arrangement; or who must touch definite objects in series in a particular manner as they go; or who, should they not *first* recall some especial memory or word or phrase, or count up

to so many, cannot do this or that feasible act they wish—possibly even when desiring coitus are impotent until the obsession is satisfied by the performance of the irrelevant and absurd proceeding, namely, of making certain counts or other utterances or movements. With this is more or less of a painful, often anguished, state of feeling, with sense and idea of vague or definite evil to ensue—of mental perturbation to the self—if the act be not done, also of necessity to do the act, and painful inquiry as to the wherefore and nature of the morbid state.

Fundamentally and essentially in part the same, the abulic besetments differ in type from the others, inasmuch as they show impotency of will, manifested in mental powerlessness to do some simple ordinary act.

Some obsessed persons get sudden anguish about imaginary impending stroke of disease or suicide or death.

In their more simple forms obsessions are merely slight and elementary mental conditions of abnormal type, which it is scarcely correct to call mental disorder or derangement, and with some of which it would be absurd to deal, practically, as an insanity in the legal sense. But this is true only of the more simple. At each step, as they pass to the more severe phases, they increase in importance, become progressively detrimental, step by step more engrossing, enthralling, and subversive of mental soundness; and at each enhancement of degree becoming of greater forensic value, more and more a mental subjugation and slavery of the affected person, destroying his usefulness, controlling his life, and making him, if dangerous, ever increasingly dangerous to himself or to those around him. Fortunately it is not always thus: the condition may be recovered from; it may undergo improvement; it may remain at a standstill, or practically make no advance.

Obsessions are among the stigmata of the insane diathesis in many cases; they are among the stigmata of hereditary mental degeneracy. In an elaborate and advanced form they pass into a variety of insanity and rule the subject's life. They have close relationships to neurasthenia, paranoia, hypochondria, hysteria, and to some cases clinically, in part, of melancholic type. Nor are they without noticeable relations to epilepsy, and, perhaps, to chorea. But, later on, we shall see that, nosologically, they must be kept distinct from all these. Like neurasthenia, obsessions may be acquired. But a host of neurasthenias are essentially of

hereditary origin, and if obsessions co-exist the neurasthenia and they are concomitant evidence of the hereditary morbid weakness or defect. This last is the natural fertile soil for neurasthenia, obsessions, paranoia, hypochondria, hysteria, melancholic forms, and many other morbid psychoses of the great group marked by hereditary mental degeneracy, which are inextricably bound up together as fruits of the same soil. Thus there may be:—1. Neurasthenia. 2. Elementary disorders of mental action. 3. Fully-developed degenerative psychoses, such as those attended by hypochondriacal or by persecutory delusion.

It was under the name of “*monomanie raisonnante*” that Esquirol published his case of insanity of morbid doubt and fear of contact with certain objects. Under the same heading he included cases without such symptoms, namely, two of his own; and four exemplars of so-called moral insanity, published by Prichard. And, nearly 30 years later, it was as “*monomanie avec conscience*” that Baillarger brought forward the instance of one with fixed painful ideas and terrors as to writing material, especially pencils, who could only attain calmness when watched by two persons, who also lost herself in *ifs* and *perhapses*, and was practically quite insane.

Under the title of *délire emotif* (taken to be a neurosis of the ganglionic nervous system) Morel set forth cases marked by exaggeration of sensibility, impressionability, and emotional facility. Hence, in different cases, over-impressionability, irrepressible childish tears and sobs, and a terrible fuss about trifles, sometimes followed by spasm or convulsion; horror of heights, fear of falling in steep places, fear of contact of objects, perhaps suddenly appearing and ceasing, or tending to a panphobia; causeless fear of rabies, hypochondriacal fixed idea, hysterical hyperæsthesia, constant preoccupation as to the nature and causes of the “fixed ideas.” In some examples the condition began after a physical or mental shock, with sensation as of a blow in stomach or chest, followed by fear of using some common simple things, as knife or key, and inability to use them. Rarely, hallucinations or tendency to homicide or suicide followed. There was inability to do rather than impulse to do, *e.g.*, certain objects could not be touched, certain articles could not be used, and urgent attempts to touch or use them would sometimes bring on spasm, convulsion, or syncope.

Prominent are the disorders of digestion and circulation, the facile creation of morbid emotion, the instantaneous implantation of certain fixed ideas producing baseless fear or impulse, so to speak, irresistible; ridiculous terrors which sometimes become panphobic; the affective and moral perversion.

Under one title or another, the older literature contains examples of one or other of the forms of besetment. Thus, to take the morbid fear engendered by the perception and idea of spacious rooms, churches, temples, wide streets, and public squares; long before Westphal in 1870 called attention to it, examples had been described by Brück, who termed it "*Schwindel-angst*." Sauvages had mentioned cases of it under the head of *vertigo hysterica*. And Petrus Forestus* gave an example, observed in 1572, under the preamble "*de vertigine cum cerebri imbecillitate*."

Now this is only one of a group essentially of the same intimate nature, the morbid dread and idea engendered by particular kinds of places or aspects, *e.g.*, the similar dread and tumult aroused by being in close quarters or narrow spaces, that produced by seeing crowded throngs of people or crowds in movement; anguished dread from being on heights, from seeing any precipice or even slight depths below; or dread engendered by being in the open without shelter overhead, and in Brück's case assuaged by putting up an umbrella. The fear may be a fear of losing footing and of falling, or of losing consciousness, or of becoming vertiginous. With the sense of personal insecurity is an overpowering leading conception, *e.g.*, of inability to proceed, or to stand, or to escape, or of being gazed at and remarked upon.

These various morbid distresses, like the torment of the self-questioning and other obsessions, are congeners; are different manifestations of a common pathologic state.

J. Falret (*fils*) described the true basis of the condition as a general disposition to return unceasingly to the same ideas or acts, to experience the emotional need to repeat the same words, or scruple to do the same acts, without ever succeeding in satisfying or convincing oneself; a perpetual state of internal hesitation; an inability to arrest this incessant labour of thought which exercises itself on itself without reaching any definite result. Hence Falret (*père*) termed it

* Frankfort edition, 1634, p. 372. Dr. Emil Höring, who first cited this, refers to an edition of "1614."

“malady of doubt.” For some of these insane are tormented by religious scruples, and incessantly reproach themselves for the ideas which spontaneously arise, or for the most insignificant of the ordinary acts of life; others are occupied in chasing certain ideas, or in trying to hold those which incessantly tend to escape from their recollection; others, and this is the most frequent he said, are in perpetual fear of touching external objects with their hands or any part of body or even dress, dreading that these objects are defiling or injurious to them, or having some abstract scruple as to the possible effect. These fears react painfully on the details of their lives; they cannot live the common life. Thus they may be prodigiously long in dressing, in getting seated at table, may dread to put food to mouth, or to walk lest they soil the ground with their feet, may avoid others so as not to run the risk of shaking hands or of grazing them with their clothing, and shun the touching of all, or of certain, external objects. Having involuntarily touched something or someone with hand or dress they must wash the hand or put off the defiled article of clothing. From this, again, arise new doubts, new perplexities, and new tardiness in the accomplishment of all the acts of life. They speak constantly to themselves on the subject of their mental state, and, not content with this, experience the need of reporting these anxieties to others. Most of those affected reach a complete mental disorder. Thus far Falret; and we find in his cases the mysophobic fear of being touched, defiled, or injuriously affected in some way by contact; or else a fear of touching, defiling, or injuriously affecting other persons or things.

I would urge the absolute abolition of the designation “*délire du toucher*.” By it was named that which is not a *délire du toucher*; but on the contrary is usually a morbid anxious dread of, or of a quality of, some environmental thing or condition; occasionally also, or solely, relating to direct contamination by the self; whether or not with this dread may be clearly defined obvious morbid doubt, hesitancy, indecision. The conceptual and emotional state is that of fear of contact with this or that kind of object, or with many, or of the effect of the *self* upon *others* or on things; and relates to defilement, foulness, contamination, disease, poison, virus, vague or subtle ill-effect, therefrom; or some superstitious fatalistic notion arises in that connection, which im-

presses itself insistently. And very often with this is some form of the questioning torment.

But, in spite of precaution, contact is sure to come, and to bring to the sufferer's imagination all the evils so abhorred. Hence an ever-renewed urgent pressure, impulsive, and as it were automatic, to wash the hands, or it may be face, or articles of clothing—and to wash them over and over again with morbid persistency. And hence some of the prolonged wearisome repetitions, doings and undosings, thousand plans and stratagems, attempts and imagined failures, renewed strivings and insistent repetitions; so that torturing hours are consumed in the process of dressing or undressing, of paying attention to the calls of nature, or of doing some other simple everyday act of life—but now done with the wearisome magic ceremonial of morbid precaution, hesitation, and doubting fluttering vacillation.

Of these we may take mysophobia as the type, as one of the earliest and most frequent forms observed. But the tyranny of the name has sometimes led to such cases being misunderstood as mere fear of dirt; dirt, as simple dirt, being not amiss to many of the subjects of morbid fear of contamination or defilement.

But more simple, more elementary, more fundamental than this, is an utterly different condition, and one with much more right to be designated *délire du toucher* than has that to which this name has been applied (except when otherwise applied under misapprehension). It is a condition which I term the *besetment* or *obsession to touch*. It has been almost neglected, and is only incidentally mentioned as an element in a few particular examples of obsession. Nevertheless, I believe it to be obsession in one of its purest and most simple forms; yet capable of undergoing development through all the grades into definite insanity. Here and now I desire to give it its due place, and afterwards to support this claim, not merely by reference to examples within my knowledge, but also by citation from the romancer already referred to.

Then let us for ever cast away the name “*délire du toucher*,” misleading, erroneous, pernicious.

Of like position with the *besetment* or *obsession to touch* or *to touch in a particular way*, is that of ordering and arranging the steps, or touching or kicking with the feet, or making other especial movement, tap, or magical ceremony with them. The simplest is the felt need to walk on the pavement, floor, or footway, with paces so many to the piece of

wood or stone, to avoid stepping on the lines of junction of the component parts of the footway; or, contrariwise, to be anxiously careful to step on them, or to miss none, or to begin or end with left foot or with right.

The hand and foot performances just described; and the counting impulse; and the impulsive need to repeat the same word or phrase; are perhaps the four simplest forms; and the usual underlying psychic groundwork is that of anxious emotional hesitation, indecision and faltering doubt; paroxysmally recurrent.

II.

THE PSYCHOLOGICAL AND CLINICAL POSITION OF MENTAL BESETMENT OR OBSESSION.

A. What is the position of mental besetment in relation to the psychological division into—*thought, feeling, will*, which we may use here whether we like it or no?

It has been held that neurasthenic obsessions are lesions of *will* from disorder of central reaction (differently from lesions of will in ordinary insanity held, by the same, to arise from disorder of centripetal excitation). Also, that they are divisible into impulses and abulias according as the power of "voluntary" arrest (inhibition) is affected, or, on the contrary, the power of "voluntary" action—there being in the former case insufficient inhibition; in the latter, deficiency of motive energy.

In obsession there seems to be a morbid activity of part of the memory apparatus (if we may so speak). Roused on a sudden with morbid intensity the memory or "idea" forces its way, and in its rush the activity of the motor mental apparatus is involved, and is apt to be compelled into the service of the compulsive idea. Capable of being curbed at first and in the minor phases or attacks, the impulse to act may become irresistible in the graver forms or at the height of the besetment. And, as a rule, therewith is a burst of hurried fear, of dread alarm, or of horror and affright. Indeed, in some cases the erratically aroused and morbidly intense memorial image is of emotional type mainly: *the dread or fright takes the leading part and control.*

Yet it has been held that (straining and limiting the use of the word) "ideas" are the essence of the mental state; or, as one might prefer to say, that the condition is essentially one of disorder of thought-elements, in con-

sciousness. In this view, I take it, the sudden emergence and insistency of the imperative conceptions would be the great *moment*; and any emotional accompaniment would be held to be secondary, and, at least, for the most part, due, as alleged, to the conflict between the besetting thought and "the will," the latter in anxious revolt striving against the besetment, and the strife being mentally painful or torturing; or, if the obsession is an abulic one, the agonising distress flowing from the helpless feeling of powerlessness to do some trifling simple act. The apparently sudden implantation of the intruding imperative conception is often surprising to the obsessed himself. So is the equally facile emotional stroke.

But I think that here the proper "organising idea" is that, broadly viewed, besetments invariably tend to, and usually are, a blending of anomalies of all three: *thought*; *feeling*; "*will*." The tendency is always present; the blending produces the usual and composite state.

Truly, there are cases in which imperative insistent dominating *conceptions* of recurring labile remittent or intermittent fixity, hold first place, lead to no important act, are not very noticeably accompanied by emotional disturbance; and truly there are others in which disorder of emotion and of action is secondary to the erratic play of the compulsive thoughts.

And there are others in which an *impulse to act* or an irresistible one seems to be the chief and leading symptom; the act, like a reflex one, sudden, the idea of it scarcely conscious ere accomplished in the corresponding act.

Yet, in still other instances *morbid fear*, terror or horror is apparently the predominating mental condition. But even here there is a conceptional element which may be a co-equal, and, possibly, a fundamental one. And in some cases the morbid fears aroused by particular objects or sensorial impressions spring forth on the mere memory of these.

Consequently, while maintaining that disorders of thought, feeling, and "will" are usually concomitant and blent in obsession, and that the tendency to such blending always exists, one must also say that there are cases in which

- (1) Disorder of *thought* seems to be the chief fact, and may be taken as so; yet in others
- (2) Disorder of *feeling* seems to be the chief fact, and may be taken as so; and in others
- (3) Disorder of "*will*" seems to be the chief fact.

For this reason, and for convenience, I have been accustomed to speak of the main varieties of obsession as grouped under "The Three D's," namely, the besetting Doubts, the besetting Dreads, the besetting impulse to Deeds. Or, respectively, the besetments of Doubt, Dread, and Deed, according as Doubt, or Dread, or Deed (Act) is, respectively, the apparently leading and title rôle in the morbid drama, but in each case supported by some form or degree of the other twain factors; certainly at least being so in the later, fuller, stronger manifestations of the malady.

And here I use the words "Doubt," "Dread," and "Deed" in a widely comprehensive meaning of each:—

The Doubts as including, not merely morbid dubiety in the stricter sense, but also such conditions as the presence of insistent words or fixed propositions, involuntary uncontrollable questionings, metaphysical refinings, mental whimsical raking-up, rummaging, searching, prying or rumination; anxious inquiries, intellectual impulses, morbid notions of defilement, or of contact, or of touching—all these being of special type and character:—

The Dreads as including the "phobias" proper, or at least their most striking feature, and varying from slight seizure of mental pain, vague *malaise*, a perturbed, restless, straining, uneasy expectant state of mind to one of paroxysmal, profound dejection or dread or nameless horror; and all these of special type and character. Nevertheless, in some cases, no dread is distinctly felt, at least in the early phases, but an agitated fluttering feeling, a wavering vacillation, "variable as the shade by the light trembling aspen made." This may precede and accompany precordial anxiety or illness, which becomes urgent if mental shocks affect, or chagrins or worrying threats annoy, or dangers confront, the unhappy sufferer:—

The Deeds as varying, one might almost say, from the ideas of acts to do, or merely nascent tendencies to action, up to those which force their way, must be stoutly resisted, are resisted, and, after a struggle, may be successfully restrained "by will"; and through these, up to those which are resistless and accomplished with a torrent outburst of quasi-convulsive force, incapable of being restrained by the relatively weakened "voluntary" energy.

The morbid condition often is manifest in the inability to do some simple ordinary act; powerlessness and invincible

repugnance to touch certain objects, to use some simple article; or in dread of approaching or opening a window or of mounting the least height. These may follow physical or mental shock, and may be ushered in by epigastric, precordial, or cardial, strange and sudden sensations. Abulia, or inability to do, is important, but less so than uncontrollable doing, in obsession. The attempt to do the obsession-forbidden act may produce physical tumult and disaster; even convulsion or syncope.

Therefore in the motor and voluntary sphere, and in contrast with the impulsive acts, we may admit, also, such as were long ago reported by Morel, and recently named the abulic obsessions by Régis; those impotences due to recurring deprivation of will-power, a sort of psychic helplessness and incapacity to voluntarily fix thought or to act; or short, recurring, mental paralysis of action.

Of this kind are cases such as one in which the patient could walk on a floor divided into squares, could go up and downstairs, but from fear of a fall could not walk on a smooth floor, falling in the attempt; yet was able to walk on that or any floor by stepping over a cross-piece attached to the lower end of a walking-stick (Sovetow); or cases of paroxysmal distressing besetment of inability to rise up, to climb a stairway, to dress oneself, to speak, or write, or fix thought, or enter a door, or seat oneself at table.

Allied to this is functional inability to walk, although the limbs can be moved freely and strongly; or delusion that limbs are of some brittle substance, leading the affected not to move them; or dread of tabes producing tabetiform symptoms.

But while the above is a correct and convenient classification, neither disorder of thought, nor of feeling, nor of "action," alone, is, *practically*, ever the sole and pure mental element of an obsessive besetment.

The "doubts" are in some cases so comparatively free from emotional accompaniment as to be spoken of as forming a "non-emotional" variety of imperative ideas. But certainly when advanced in development they always have emotional accompaniment. And I believe that at least in many, and probably in all, cases termed non-emotional there is, even at an early stage, some, perhaps slight, accompanying disorder of feeling, some of that disturbance of the fundamental feeling of existence—or

“nervousness”—which I have already mentioned as an agitated, fluttering, uneasy feeling of wavering vacillation; one which often co-exists with, or with a tendency to, precordial anxiety and painful sinking, to sombre tone of feeling, to gusts of ill-ease and sadness—or the tremulous tumult of vague, dimly-felt foreseeings and mental foreshadowings.

Similarly, the doubts may appear to be distinct and separate from the “acts,” but in all cases of the former I believe there is action of some kind, or a tendency thereto, action in a nascent form at least. And in many cases there are distinct impulsive acts, and these, in some examples, are the phenomena of supreme importance from the forensic aspect.

That the imperative thought may be prior to and more prominent than the accompanying imperative emotional feeling is compatible with the nosological position we assign to the cases presenting it. For in paranoia, some forms of which are closely allied with and may follow obsession, intellectual disorder precedes the most striking perversion of emotion shown—although some moderate or slight disorder of emotional feeling precedes in most or in all—and the eventual clinically pronounced emotional state, in cases pre-eminently of insistent dominant delusions, is secondary and reactive to the delusions and hallucinations.

Moreover, the suggestion of the act to the mind by and in the compulsive idea—whether this last be successfully resisted or not—implies and requires the arousing of motor ideas involved in the act as the immediate antecedent. And if we admit a primary division into obsessions approximately mental only, and those with overt impulses to act as well, the full development is by imperative compulsive thought, anxious emotion or fear, and the culmination in impulsive uncontrollable act.

The “dreads,” therefore, are sometimes quite secondary in their pronounced form. Seemingly, in some degree they are practically invariable (or nearly so) in the imperative or compulsive conceptions; and they lead to motor expression of feeling and to involuntary action, which may vary from the merely nascent or slight to the active or even violent and destructive. Moreover, in the dreads there is indissolubly blent a large share of intellectual elements; a complex state in which thoughts and feelings are unwoven. The word

“idea” I do not use just here, for in this relation it is an ambiguous term.

In mental besetments, the limited power of self-control *quoad* attention, has a resemblance to that of the hypnotic state, and the leading part taken by attention in those mental phenomena, and the manifestation, in them, of “tonic cramp” of attention, have received notice; as also the relation of the mental attitudes to physical reactions. It may seem as if the channel between ideation and (sympathetic?) nerve became so free and direct that the usual sequence is changed to one of “fixed idea,” heart-quake, and conscious fear. “At all events this last is swiftly overtaken by the automatic organic attitude of fear; and this quick reflex from the idea undoubtedly increases the fear; the man is frightened by his own trembling; he is a coward upon instinct. This amounts to mental suggestion from the physical field” (Cowles). Obsessions may have sensational elements: strange and controlless sensations about head, extremities, chest, genitals, abdomen.

Similarly of the *acts*. The more they are thoroughly investigated, the more of intellectual and emotional accompaniments do we find; the attention of observer and of subject is so inclined to fix on the strange incongruous or dramatically dangerous or fatal acts that the relatively little-conspicuous conceptional and emotional disturbances may fail to arouse notice.

Nor do the acts stand alone, otherwise. The strangest “bodily” feelings and changes precede and accompany them—head-pain, strange sensations seeming to mount brain-wards like auræ; feelings of heat or of constriction about abdomen, chest, throat, or head; anorexia, griping pain, burning at the epigastrium, sudden intense sensations of heat; pallor, sweats, flushings, thumping heart and bounding arteries.

The bad effect of overwork, mental or physical, and of any strain, exhaustion, inanition, any depleting drain on the nervous system, in promoting obsession, needs only to be mentioned; as well as the current error, thereanent, which leads to urge upon the obsessed what, to them, are modes of physical over-work and irritating kinds of so-called distraction of the thoughts.

III.

GENERAL CHARACTERS OF MENTAL OBSESSIONS IN THEIR PURE
AND PRIMITIVE FORM.

As to their *general characters*; obsessions often have neurasthenic physical accompaniments. Their occurrence is usually based in hereditary mental degeneracy. They are fluctuatingly remittent, or paroxysmal; and liability to them is of indefinite total duration. As to their psychic characteristics; at first lucidity and consciousness of the morbid nature of the mental state are retained; anxiety presses, or distress; attention dwells on the malady; dejection and *tedium vitæ* often accompany; and, usually at least, there is tendency to paroxysmal conscious impulsive act, which often becomes irresistible. Hallucinations are absent in the uncomplicated cases. Obsessions often are related to a particular set of conditions both as regards occurrence and recurrence. Similar surroundings or incidents recall and suggest the previous obsession. Some actual untoward incident, or natural anxiety, or fear, may appear to be the starting-point.

Falret characterised obsessions as accompanied by the sufferer's consciousness that the condition is a morbid one; as being usually hereditary; as remittent, periodical, or intermittent; as not remaining isolated mentally in the form of monomania, but extending to a wider sphere of the intellectual and emotional life; and always accompanied by anguish and anxiety, by an internal struggle, hesitation in thought and in act, and by physical symptoms more or less pronounced of an emotional (nervous and mental) nature; but not by hallucinations. Furthermore, that the same psychic characters of the symptoms are retained throughout the whole future life of the subject of them, notwithstanding frequent and often prolonged alternation of exacerbation and remission, and they do not pass into other forms of mental disease or insanity, nor ever terminate in dementia; and that, rarely, they may be associated with persecutory delirium or that of anxious melancholia at a later period of the disorder, but even then preserve their primitive characteristics.

One cannot fully accept some of these asserted characteristic features. Nor that there is always the need to assuage the doubt by seeking the testimony of others.

The clinical states in besetment are not always the same in degree and intensity; they vary much in these respects and in correspondence with a number of circumstances or conditions. They may be mild or severe; in occurrence, comparatively frequent or seldom; short in duration, or long drawn out; severely paroxysmal and acute in attack, or more chronically and deliberately falling and rising with moderate fluctuation and swell.

IV.

BESETMENTS OR OBSESSIONS MUST BE DISTINGUISHED FROM SEVERAL OTHER CONDITIONS.

The sudden irruption of the elements of obsession from below the threshold of consciousness may remind one of the epileptic insultus. Yet the condition is not an epilepsy proper: it is not a masked epilepsy. There are not dreamy states of consciousness, or anything similar thereto, as a *primary* condition; although mental confusion may come, and even to a chaotic degree, as a secondary affair in some few cases and in consequence of the irresistible and tormenting urgency with which the sufferer must follow the train of his thoughts, which change with ever-increasing rapidity until they are obscured in a confused mental eddy or whirlwind. But these secondary states occurring in some examples of obsession are fundamentally different from the *primary* mental "absence," momentary obscuration, imperception, or dreamy mental states and reminiscences, of some cases of epilepsy. Obsessions *may* immediately precede the convulsions of epilepsy, as *auræ*, or may occur in epileptics during the quasi-lucid intervals between convulsive bouts when the mind is not *immediately* affected by the epileptic seizures; but this is another matter altogether. Here, also, usually at least, are conditions of degeneracy as well as of mental reduction.

We may compare for a moment the general characters of obsession with impulse, and the general characters of epileptic uncontrollable impulse.

In the *obsessed* case the general characters are:—

Retention of full consciousness, or of fairly full. Usually clear recollection of the attack.

Concomitant anxiety and anguish.

Insistent dwelling by the sufferers on their condition.

Tedium vitæ.

Physical signs of cerebral neurasthenia, frequently.

In the *epileptic* case the general characters are :—

Suddenness of onset.

Unconsciousness, or dreamy state, or great mental obscuration, at the time of impulse.

More or less complete loss of recollection of attack, afterwards.

Often precise similarity of the details of several impulsive paroxysmal seizures and acts.

Therefore, the great distinctions between the two are that in *obsession with impulse* there are, more or less full retention of consciousness during the impulsive seizure, followed by clear recollection of the attack; anxiety or anguish; engrossed dwelling on the state; neurasthenic accompaniments.

Whereas in the *epileptic impulse* there are the more periodical paroxysmal occurrence; sudden onset; degrees of unconsciousness followed by complete or incomplete amnesia of impulse and act.

Ordinary or somewhat unusual hysteria must not be mistaken for obsession.

Nor must hypochondria with a dominant set of morbid ideas of ordinary type, be confounded with the compulsive besetting ideas and feelings.

Mere strains of reminiscence, such as the temporarily haunting bars of a popular melody, must not be taken as pathologically in line with mental besetment, although useful for purposes of simile.

Idiosyncrasies are not obsessions. Thus, he was idiosyncratic but not obsessed who always broke out in a severe red rash of special type whenever he partook of gooseberries, and only then, and who, drinking spurious champagne when a guest at dinner, to his astonishment found this rash make appearance with all its usual concomitant symptoms.* Yet the contact of certain harmless objects; the sight of the same or of others; the hearing of particular commonplace sounds; the odour or taste of some ordinary things; may give rise to conscious paroxysmal distressing anxious

* Mr. Geo. Pollock's Introductory Address, St. George's Hosp., Oct., 1895.

obsessions presenting characteristic mental and physical symptoms.

Nor are secondary sensations (phonisms, photisms, etc.) of the nature of imperative feelings proper.

Ordinary cases of insanity with "dominant" delusions or hallucinations do not, or do not necessarily, exemplify obsessions proper.

In each of these respects, and in others to be mentioned, conditions have been termed imperative ideas which in my opinion are not suitably placed in that category. Further on, we consider the close alliances of obsessions with convulsive tic, jumping disease, myriachit, and latah; and in respect of these also some differential distinctions must be made.

And the use of the term "fixed ideas" by some, as synonymous with imperative ideas or with obsessions, is unfortunate, since "fixed" was already a very useful term in psychiatry, applied to other morbid ideas. Nevertheless, when imperative conceptions become so constant and urgent as to constitute an insanity they are, and may properly be described as, a particular variety of fixed delusion, or of morbid insistent or morbidly dominant ideas. But to attempt now to confine the qualifying words "fixed," "dominant," to ideas which are of obsessive character—or to describe all such as obsessions, and all obsessions as such—is to introduce confusion into nomenclature; and is open to grave objection.

Parasitical, and quasi-parasitical, are qualifying terms which have also been applied to imperative ideas. But in most cases, at least, those from which they spring are essential and fundamental elements in the web of mental being. And it thus innate, in a sense; if their potentiality of existence is thus laid down in the foundations of the organism and merely awaits favouring circumstances to develop, or if, in some cases, they evince themselves even under conditions apparently most favourable to mental health, they are not essentially parasitical; and the parasitic semblance is only superficial, and from one and not the most important point of view.

V.

(a). THE TRANSFORMATION OF OBSESSIONS INTO INSANITY.

(b). THE SCALE OF OBSESSIONS FROM THE TRIVIAL TO THOSE WITH DESPERATE IMPULSES.

For convenience, and to save repetition, these two connected divisions of the study of mental besetment are taken together under one heading.

Many have fallen into the error of supposing obsessions to be always unimportant, and simply odd incongruous absurd conditions, amusing to the onlooker, although at last painful to the subject of them, or becoming so in most cases. And the next step usually taken reaches the major error of deeming obsessions to be always quite distinct from and unconnected with insanity.

Distinguishing tests have been framed between the two. Thus obsessions have been distinguished (Morel) from insanities by:—

1. The different interpretation of their condition made by obsessed persons from that made by the insane.

2. The absence of hallucinations and illusions in the former.

3. The absence of changes of personality in the former.

Yet cases break through these distinctions.

I must first briefly refer in a general way to impulsive conditions of insanity.

Impulses occurring in many kinds of insanity, and much of insanity viewed at large having something of an impulsive character, in its reductions, failure of inhibition, and lack of control; the impulsive phase is found especially in certain case-groups—namely, in those strongly-disposed hereditarily; in the insanities at the critical periods of life; or attending disorder of generative organs and functions; or various conditions of epilepsy, or of alcoholic overuse and disease. Imitation, also, may be a factor.

In this relation, the study of the mental-degenerative insanities is important; and one sub-group of these has as its simplest and least developed exponent the intensely interesting form in which the most striking symptoms are either morbid fears and doubts—anxious obsessions—or compulsive thoughts—conceptions of imperative character;

together with their effect on acts and conduct. For there is one form (simple hereditary insanity) in which a special type of impulsive symptoms is so marked as to almost characterise the malady; but essentially manifested by what at first are the lighter and trivial, harmless, and often absurd forms of compulsive thoughts or acts, and therefore casting light on the dangerous or deadly acts fundamentally of the same nature.

Following, rather, the line of dissolution in hereditary and degenerative insanity, we find these compulsive thoughts and feelings. They bear witness to a morbidly impressionable nervous system; often spring suddenly into being as if brought forth explosively and like a convulsion; either from some obscure and unknown incitation, or at the bidding of some trivial suggestion, utterly inadequate to effect the same result in the healthy mind. The compulsive thought is often associated with affective perversions, morbid antipathy and opposition, or with the existence of systemised delusion; is itself frequently a rudimentary delusion; occurs, like the impulsive *act*, often in hereditary mental degeneracy; or else in young, in pregnant, puerperal, lactating, or menstruating insane females; also at puberty and the change of life, or in cases partly of alcoholic or of traumatic origin, and it may be found in others.

The compulsive thought may be traced, in different individuals, from the most trivial to the gravest of its forms. Thus, there may be merely a recurring idea, recurring aberrant absurd thought; or there may be, of this kind, such as enter, hold possession of the mind, and are devils which cannot be cast out; or the sufferer may be tormented by morbid fears and painful conceptions, so severe and so fixed, at least for the time, as, also, to receive names as special forms of mental change, or even of insanity.

Impulsive Acts.

From the compulsive thought or imperative conception, or from the compulsory feeling, springs the cognate impulsive act, which perhaps might be more distinctly specified as the *compelled* act. It may present itself as an isolated single act; may frequently recur in the nascent form, or pass over into action, may even remittently, or, for a time, constantly, dominate the whole life. Like the compulsory thought, so the impulsive (compelled) act may be traced in

different individuals in its various degrees of development and importance; and these degrees may be observed from time to time in the same case.

When such an impulse culminates in a fierce criminal act, jury and judge are apt to look askance at and to disfavour medical evidence which testifies to the constraining effect of such impulse on the acts of those subject thereto. Such evidence is apt to surprise and repel the legal mind on the bench, the popular mind in the jury-box. But this prejudice or preconception melts away from the mind of the observant student of clinical psychiatry when he traces the impulsive constrained thought and act from small beginnings and trivial results, through a gradually ascending series of more important effects, up to the fulminating act—up to the consummation in some desperate deed of crime; or when he finds examples of all these degrees separately in the individuals who may be arranged in a graded series.

In the simplest form, the compulsive thought and compelled act in question are merely a constraint to perform and the performance of some trivial act; such, *e.g.*, and already described, as to touch a series of objects in a certain way and order of succession;—to walk with steps regulated so and so; to count up to so many; to do this, or to utter some particular word or phrase before accomplishing some act of ordinary custom; to get other persons to do or say something trivial, of analogous nature to the acts just mentioned, and having a similar object; and to do this, at least in many cases, lest evil should befall, or lest the mind of the sufferer should be disturbed. Lest evil should result, and lest mental disturbance should occur; for in many cases there is not merely the feeling of compulsion to the act but also a painful conception as to the necessity of the act, and as to the vague evils which impend if the impelling force be resisted or thwarted. Besides which, there is a feeling of anguish, and a painful inquiry concerning these morbid states of consciousness.

And, following the course of deepening dissolution, from these—the slighter and less important manifestations, as regarded from a social standpoint—we reach destructive and mischievous impulsive acts, so frequent in the insane, and we reach those which so often bring the subject of them into conflict with the penal law. The impulse may be to theft, drinking, fire-raising, self-killing, murder, etc. A proportion of all these impulses are derived from obsession

—obsession which has become aggravated, or has passed into what one might call “possession.”

I have already warned against the error often made of supposing obsessions to be unimportant and merely odd, absurd, and incongruous conditions, although at last painful to the patient; and against the allied error of deeming obsessions to be in all cases quite distinct from and unconnected with insanity. That these are errors is evident from the preceding considerations, which may be briefly summed up as follows. They are errors:—

A.—1. Because the sufferers from obsession tend to, and sometimes end in, one of the more severe forms of paranoiacal insanity:—

2. Because the condition itself may become exaggerated and modified, so as to pass from that in which its absurdity is recognised by the person affected to that in which there is conviction of its reality as truth, and the belief is acted on, governs the life of the person, and, for the time being at least, necessitates his isolation from the general community:—

3. Because the acts, or tendencies to act, vary from the easily resistible to the difficultly resisted, and to the irresistible, by a long and graded scale:—

B.—4. Because the acts vary from the slight and trivial vagary to examples of self-killing and man-slaying.

In one set of cases these felonious acts, or fire-raising, theft, etc., are examples of obsession—of true compulsion of the obsessive type. They form a distinct part of the total cases of each variety of the so-called impulsive acts, whether harmless or criminal.

Hence the enormous forensic importance of obsession. Thus, a share of the examples of results placed under the heads of destructive, mischievous proceedings, indecent exposure or act, theft, incendiarism, criminal assaults, suicide and homicide, are of obsessive origin and type. Side by side with these, and shedding upon them an illumining light, are the simple vagaries issuing in whimsical singularities of act, perfectly harmless to others, amusing to the general, mere oddity, perhaps, to the victim at first, but subsequently often an afflicting, driving slave-whip, or grip of fettering constraint.

The transition, psychologically, from the simple morbid fear or involuntary compulsive feeling or thought, to

insanity — especially the insanity of doubt — seemingly consists in a transition from a state in which the patient recognises (perhaps laughs at) the incorrectness, inaptness, irrelevancy or absurdity of his thought or feeling, to the vesanic state in which he is engrossed by the vivid reality and validity of the feeling or thought, so that by it the life is essentially altered and the acts are largely dominated — in which, therefore, a truly delusive impress characterises the mind.

In the foregoing the *questioning* malady has been taken as a department of the *doubting* malady — of the besetting doubts.

If the subject is insane, with the delusion of doubt may be other forms of mental degeneration — *e.g.*, persecutory delusions or hypochondriacal ones; notions on his part that anything heard or seen refers to the patient; conditions such as dread of various kinds, fear of contact, or of defilement, fear of glass or needles; attacks of anguish and precordial anxiety; associated in some insane cases with delusions of suspicion or of poisoning; with hallucinations; and with despair.

On the question whether the so-called kleptomania, pyromania, suicidal- and homicidal-mania are distinct and separate forms of insanity, or are merely symptom-groups, we hold that they are the latter only.

In reference to the dangerous and destructive tendencies in obsessed and in allied cases, and to the need for legal power to control, restrain, and isolate the persons thus affected, a few lines are now cited in relation to one who is considered to be the father of Nihilism and anarchical dynamiting:—

“Fifty years ago an eccentric, impulsive individual lived at Dresden. He came from Russia, whence he had been banished. . . . He had the mania for destruction to a point so extreme that if one did not take care to distract his attention he could not look for some time at any object without wishing to break it into pieces. An idea of his state of mind may be formed from the following anecdote. At a dinner given on the occasion of the marriage of one of his friends, and at which he had fulfilled the functions of a groomsman, he committed the most extravagant acts. He had constructed with the crockery and glasses a sort of scaffold, which the assistant feared would fall at any moment. He was persuaded to undo his work piece by

piece, instead of throwing it down at one blow, in the same manner as he wished to destroy all the Governments of Europe. But he was so excited that he took a Bohemian glass, broke it with his teeth, and swallowed the pieces." And, although this is another matter, he seems to have been regardless of the feelings and opinions of others, even of his "friends," for we read that, "a scalp disease compelled him to shave his head and he wore a wig, which he took off whenever he was not in a public place—that is, when in a friend's house, or wherever he was a guest, without caring for the opinion of those to whom he thus exposed the anatomy of his denuded cranium."*

VI.

THE RELATION OF OBSESSIONS TO PHENOMENA IN PRIMITIVE MAN AND IN SAVAGES, AND TO CONDITIONS IN ORDINARY FORMS OF PARANOIA.

Firstly, in relation to obsessions in general, and for the moment more particularly to those different and composite conditions classed under the name of "onomatomania;" the germs of obsession are to be sought in primitive man, in savages, and in the phases of mental development through which civilised man has passed from savagery.

In the mentally degenerate person the early prior phases of thought in the race, long thrust aside, overgrown by new development and forgotten, may come again into prominence in consequence of irregular and exaggerated over-development and over-function of the older organised parts of brain and mind, owing to congenital relatively weak developmental power of the more recently acquired in evolution. Whereas acute and chronic mental disease in the non-degenerate, *i.e.*, the comparatively free from hereditary mental degeneracy, by putting out of use or destroying the superior and inhibitory activities, may lead to a somewhat similar result by another path.

Hence in the degenerate, *e.g.*, in paranoia, old superstitions and mysticism may arise and dominate the insane conception and the life. But, as bearing more immediately on our present subject, there is the close relationship between full-blown paranoia and the general state in which obsessions flourish, and one so close that the latter has by some been called "rudimentary" paranoia. And in some

* *Alienist and Neurologist*, April, 1895, p. 206.

examples, both of obsessions and of paranoia, we find, for example, the formation of new words; the veneration for and the formal worship of words; a belief in the discovery of truth, or in the penetration of mysteries, by pronouncing words; the attribution of enormous importance to mere words, or of extraordinary potencies to them. Or a similar worship of, or prejudice concerning, numbers, or the assignment of potencies to them—that is, to certain numbers regarded as mystical.

These we find not only in degenerate insane or obsessed persons; but also as a relic of primitive man, in the customs and beliefs of savages of the present and of recent times, in the old mythologies and customs and sacred books, and in the literary forms and arrangements of mediæval poets, and of some modern scientists.

As bearing on this part of our subject are a number of relevant facts drawn from ancient races and their beliefs, from uncivilised peoples, from paranoiacs, and from the obsessed. There is the fabrication of new words by paranoiacs, the peculiar significance attached by them and by uncivilised races to certain symbols; new words and symbols often having but superficial relation to things symbolised. Thus, to some, a hawk on a post yields the idea of the Divinity, an ostrich feather the conception of Justice; and so on.

There is also the spell or charm, consisting of some words of occult power; the incantation, or use of certain formulas and ceremonies to raise spirits; the magical arts and effects of sorcery and enchantment by the invocation of demons or spirits, and their aid; the act of conjuration by use of certain words and ceremonies to obtain supernatural aid, to summon in a sacred name, to expel evil spirits, or to allay storms, and other the like; the enigmatical concealment of knowledge under the obscure language of a dark saying; divination by the aid of evil spirits; theurgical practices. Here, also, come many ancient, mediæval, savage, or paranoiac arts and practices, which aim at the unattainable by obscure or hidden inexplicable means; such as divination by water, by the air, by the winds, by the hand; or such as alchemy, astrology, and the hermetical philosophy. Of some of these the traces and relics are monumental, as in the labyrinths and pyramids of the ancients. Of others the relics are such as the belief still existent in magic, in the evil eye, and in measures to avoid its effects. All these

have a bearing on the onomatomania of some obsessed persons, on their formulæ and ceremonial observances and symbolisings; and those of some paranoiacs.

Tanzi states that Calabar negroes find their lot good or bad according as the owl is heard to the right or left, Calmucks according as falcons are on the right or left side. Sneezing, yawning, and spitting have a special assigned efficacy among different peoples and sects, obsessed persons and paranoiacs, as admitting or getting rid of evil spirits, or as having some analogous effect or efficacy. And the French child of the people (Tanzi) caught cheating at play, spits on the ground and utters a formula of words in order to make amends and to ward off mishap.

Similarly, we have instances both in obsession and paranoia of various protective procedures, various movements, acts, signs, or gestures; made in paranoia in order to ease the disturbed feeling, to avert evil, to thwart the adversary; or made by the obsessed in order to assuage the fear and driving impulse, and to baffle the evil chance.

Recurring episodic exacerbations of the abnormal conditions may occur also in both sets of cases; and so may the phenomenon of double consciousness occur both in paranoia and in obsession which has become insanity. Upon this subject of dual personality or consciousness, and the conditions with which it is more immediately associated, we cannot enter here.

VII.

THE NOSOLOGICAL POSITION, ALLIANCES, AND CONGENERS OF BESETMENTS.

Besides what has been said of the soil from which besetments spring, and their frequent fundamental association with neurasthenia, paranoia, hypochondriasis, hysteria, and hereditary mental degeneracy, some other of their nosological connections and alliances must be very briefly glanced at.

Not without some claim to be considered as rudimentary abortive forms of paranoia, obsessions are observed to have intimate blendings and transition phases of every possible extent and degree, on the one hand with the phenomena of the insane diathesis simply, and on the other with those of paranoia and of imbecility, of (so-called) moral insanity, of original paranoia, of hebephrenia.

There is close alliance also with some phases of hypnotism and of hysteria.

For a moment let us turn to the relations of obsessions to *hysteria*.

Like hypnosis; nervous shock or nervous exhaustion, by summation of a series of petty trials, may set up in the mind a ruling idea which tends to fixation and to recurrence, which defies abolition, is rebellious to control, and at last may become triumphantly self-assertive and insurgent. Representation is diseased: this or that representation or representation-group and its associations become over-potent.

Existing always in hysteria in some degree, either rudimentary or more developed, is a second consciousness, *i.e.*, double consciousness. In the obsessed state, so strangely different from the usual, the intrusion of the strange insistent ideas and feelings produces a state of consciousness so different from the usual and normal one that it may be taken as a condition of incipient division of consciousness, as a rudimentary degree of that formation of a second consciousness which, when completed, makes a double consciousness or personality. In obsession there is a tendency to dissociation of ideas, to disaggregation of the personality; a condition which is fundamental in the psychic sphere of hysteria. In each of them suggestibility is enhanced. In each is an over-impressionable, mobile, sensitive nervous system. In each there is failing volition, diminished control over attention; hesitation; doubt. In each the field of consciousness is narrowed, the higher brain-functions are enfeebled, unstable, labile, impulsive. The perceptions, representations, and emotional accompaniments are not properly summed up into series and fused or synthesised; hence a tendency to division of, and a second phase or form of, consciousness.

It is not asserted here that there are no differences, that the psychic phenomena are identical in the two cases. In hysteria the strange unwonted intruding, and perhaps sub-conscious, idea makes for somatic manifestation; the ideal obsession seeks outlet in emotion and act. But in either, the condition of volition, attention, association and the narrowed consciousness are destructive of selective capacity, and permit, nay invite, the easy rise of downright mental disorder of the insane kind. In each, an emotional stimulus may diffuse itself through a wide nervous arc, and occasion a series of dramatic phenomena, promoted by suggestion and directly the outcome of an irritably weak, unstable,

labile, nervous system. Thus in some obsessed persons are fear-fits or paroxysmal terrors—vague and horrible; cardiac and respiratory change, thumping arteries, dry mouth, dim vision, trembling or weak or flexed limbs and frame, or spasms; heats, sweats, urgent evacuations; or the perverted sensations already mentioned in an early section, as the epigastric and thoracic; or severe local or general pains.

Bearing on the relations between the hysteric mental state and that in obsession, a case by Kovalewsky is instructive. The following is a brief abstract of it:—

Male, 32, of neurotic family, from childhood excitable and enthusiastic; drank when young, and had frequent vertigo, back-pains and hand-tremor. At the age of 18, after hearing of his teacher's death, his mind became occupied with extraordinary force by insistent tormenting queries, and he was full of fear a whole day. Next day came a parting; the world existed for him no longer, he lived out of the world, but still spoke to others, went on his business, no one remarking anything unusual in him. This went on for two months, then he awoke in a far-off town.

For years afterwards, alternately drunken and sober, and having attacks of vertigo, darkness before eyes, leg-trembles, palpitation; nervous, irritable, sleepless; intense seizures of agoraphobia accompanied with emotional dejection, groundless jealousy-attacks, the nature of which he recognised.

A case by Ball* is worthy of mention. Everything came to look strange and queer to the patient, yet in the same shapes and colours as before. Several years afterward he felt himself diminish and disappear, and he could not regain the lost self. Everything around still seems strange, he knows not what he is, and plies himself with all sorts of questionings about existence and reality, has lost all sense of reality, believes not in the existence of himself or of others, yet he and they are "things;" nor does he believe in the existence of the objects he sees and touches. For him, the world is a huge hallucination; himself he likens to an empty paper bag, his pulse is a pulse-shadow, and when he eats the shadow of food enters a shadowy stomach. Knowing these ideas absurd, nevertheless he cannot conquer them; he cannot rid himself of the idea of his empty nothingness.

The conditions of vigilambulism, especially in relation to the subjects of dual or of alternating personality or con-

* *L'Encéphale*, 1882, p. 235.

sciousness, also bring hysterical and so-called somnambulist states into relation with obsession. For obsession may take the outward form of a driving impulse to travel, very much reminding one of the quasi-automatic perambulations and peregrinations of the vigilambulist.

But without dwelling on conditions such as these, there are several somewhat unusual maladies which have close connections with obsession.

(a.) *Convulsive-tic disease*.—After long-continued convulsive tic, mental abnormalities may appear, and obsessions frequently occur in persons affected with convulsive tic. In convulsive tic the idea of speech—or other—movement is in consciousness, and those affected have the idea of what they are about to say or do under the influence of the tic. Like obsessions, in some instances it is much affected—and either in the direction of incitement or of arrest—by the mental influences flowing from various surroundings. Moreover, what are practically convulsive tics may come for the first time in those already obsessed, and may constitute a variety of obsession.

The movements are co-ordinated, recurring in paroxysmal seizures, are sudden, uncontrollable by will, identical in the same subject, violent, quasi-convulsive. With these may be explosive compulsive ejaculation of foul language and oaths, and sometimes the imitative, and similarly forced, repetition of words heard, or of acts or gestures noticed by the subject of convulsive tic. But in its purest and most simple form, as I believe, there is merely the *tic* evinced, so that this alone suffices if it possesses the characteristics usual to acts due to obsession.

The movements in convulsive tic are of reversionary type, of a lower, simple, more infantile order, as well as of a perverted character, and by long repetition may assume a merely reflex type.

(b.) The "*Jumping Disease*" of the North American Indians has close nosological connections with obsession. Practically it is much the same disease as (c) the "*Myriachit*" of Siberian Asiatic Russia; and as (d) "*Latah*" of the Malayan and other regions. One may look upon all these three as being the same, or very closely allied if not identical.

(c.) Thus, in *Myriachit* persons, not otherwise obviously abnormal, involuntarily perform senseless, sometimes criminal,

acts, spontaneously, or in obedience to commands from others, or imitatively repeat words and acts they hear and see. This may last for years. It may occasionally be epidemic. It presents a kind of speech-obsession and of other obsessions.

(d.) Likewise in *Latah*—probably the same as “Myriachit,” but occurring in a different race and region and circumstance—the person affected executes movements and utters sounds against her will. There may be repetitions of voluntary utterances, or made at suggestion of other persons, or through imitation. The utterances are usually disconnected words or foul or vulgar expressions, or those of echo-speech. The condition is easily produced. In some cases a look or gesture by another person suffices to bring it on. Volition cannot check the movements; there is consciousness of what is being done, and the intellect is said not to be disordered. But persons with *Latah* may become insane. Hereditary as a rule, and mostly found in women, it occurs in a people possessing but little independence of thought and of action, but little individuality.

(e.) *Phases of hypnotism*.—Finally, I will merely again mention the fact of the existence of points of close correspondence between these four last-named conditions (some of which are probably identical) and obsessions, on the one hand; and on the other hand phases of hypnotism.

(f.) *Lascivious compulsive thoughts* may be true obsessions driving to impulsive indecent acts of perverted lustfulness, even to bestiality, sodomy, and congress with the dead. But besides these there are the somewhat congeneric conditions of inverted sexual feeling, so-called.

Among the many subjects raised in this address, a few may be more pointedly recapitulated:—

1. The psychological nature and clinical position of mental besetment, and those of its several kinds in their inter-relations.
2. The medico-legal importance of obsession.
3. The propriety of abandoning the use of the erroneous, misleading name “*délire du toucher*,” which, moreover, has been used in contrary senses.
4. The establishment of a neglected, little known variety of obsession as being one of the most fundamental, and representing obsession in one of its purest and most simple forms. And much of the same for a cognate variety.

VIII.

CLINICAL CASES.

In illustration of some of the preceding statements, brief summaries follow of a few of the cases observed by me, and grouped in the manner below :—

I. Those illustrating ordinary, simple, comparatively harmless, trivial, absurd, incongruous obsessions.

II. Those illustrating the increase of obsessions as part of the passage of the case into insanity, in which the obsession, now become pathological *possession*, still plays an important part, often the most important one.

III. Those illustrating the clinical, psychological and pathological relationships of the mild trivialities of impulsive obsession to the dangerous, deadly impulses, for example, suicidal and homicidal.

And under this head also (IIIa.) a case linking obsessions with impulse in insanity of more common type; and (IIIb.) a case linking obsessions with convulsive tic in paranoia.

These last two cases might well be separately grouped as a fourth set.

I have observed many more cases which exemplify the above, and other, conditions and relations of obsession.

I.

Cases of comparatively simple nature.

The length already reached by this article and the material yet to be added warn me to abbreviate here by stating the heading, only, of the first case and of the second; of which the former illustrates a very simple type compatible with hard brain-work and successful professional life, and the latter illustrates the same passing over into a condition incapacitating for pursuance of the avocation and self-maintenance.

Case 1.—Of neurotic family, a day-dreamer and castle-builder, in childhood thrown much upon his own resources as regards amusement, after having suffered severely from malarial fever which apparently altered the trending of development, mental and physical.

The obsession to touch: the obsession to walk on the pavement, etc., avoiding the lines of junction, or to walk in a particular way with steps ordered, so many, to the piece of

stone or wood. Also the impulse to count so many, or to utter some formula of words before a certain moment: or to do some other act, trifling in itself. With these, fears and ideas either of vague or of definite evil to happen to self or to others if the obsession was not placated by the especial performance in mind at the moment. Also, a vague recurring quivering, anxious dread of occupation and fixation of the mind in any one thought, which might thus cast out every other object of attention and consciousness.

In youth, the healthful training of schools with games and sports, and, later on, the severe professional studies and struggles of adolescence and manhood, aided by temperance, repressed the obsessions; and they never really troubled, nor ever advanced beyond the simple rudimentary state.

Case 2.—Admirably brought up, but as a child nervous and sensitive. In early adolescence the usual rapid condition at that age in the unstable. Later on, severe headache, and easy fatigue on moderate mental exertion, both of neurasthenic type, put an end to the higher education and to the projected professional life. Increase of neurasthenic symptoms and obsessions temporarily brought to a close the substituted commercial life which had been well begun.

Depression; obsession; the sudden assumption of the strangest attitudes; grimaces; morbid doubts. Calculations were vainly done over and over again for fear of making mistakes, rendering him worse than useless in business; repetitions and verifications of everything; dread of a simple easy journey; paroxysmal morbid dread and insistent ideas as to the most simple undertakings; the writing of the shortest letter only accomplished after many attempts and repetitions, and even then not to his satisfaction.

II.

Illustration of increase of obsessions as part of the metamorphosis of the case into insanity.

Case 3.—Male, admitted at the age of 50 years, of no regular occupation; had a little money, and friends able to support him; at one time had been an omnibus conductor. The attack of mental disease for which he was admitted was stated to be the fourth, the first being at the age of 20 years; and he had been in other asylums for the previous attacks.

At home, before admission, he had been turning the faces of the pictures, hanging in the rooms, to the wall. He

became so excited by the mention of the number *nine* that he could hardly be kept from the use of violence and terrifying language until the number *ten* had been uttered. His demeanour was strange. By his violence, he had been the terror of the home, where lived his mother, brothers, sisters and children. He expressed delusions that people were hidden in corners to startle him and prevent him from taking his meals; and in the house and out of it he walked or ran about, looking for a boy whom he imagined to have robbed him and to be hidden away in order to disturb his meals. Unless the water dropped a certain number of times when he washed himself, he would declare he must cut his his own throat, and that he could not urinate comfortably unless the people in the house sat around a table and put their hand on particular articles; and could not eat breakfast without a certain number of drawers in the room being open. He was infuriated by the utterance of certain numbers. Was wild in appearance, restless, irritable, aroused by trifles to violent outbursts of angry temper.

On admission.—Some signs of pulmonary phthisis; urine 1015, acid, no albumen or sugar. Weight 134 pounds *Av.*, pulse 100, of increased arterial tension, heart slightly displaced towards right side. The hair was turning grey. Admitted masturbation as a boy, and gonorrhœa on several occasions since. His glance, expression and aspect were very peculiar. He alleged that he had had "nervous debility" for 40 years; and was willing to be under treatment, and offered to be food-taster to the asylum. He said that but for his nervous debility, or impotence, he would have married a woman with money, and have been strong as a lion and of 14 stone weight. He was garrulous, excitable, rambled from subject to subject, evinced animosity towards a brother-in-law whom he groundlessly accused of being the cause of all his troubles. He said his disorder prejudicially affected his food-taking. As to the utterance of certain numbers his condition was still as above described. When he went into the street he was "afraid of everything flying up till he can kick it." Shortly afterwards, he was querulous, discontented, quarrelsome, looked mysteriously, suspiciously, and frequently behind doors and under plates and chairs, and was most peculiar in action and demeanour. Occasionally, he seemed to have hallucinations or illusions, *e.g.*, of objects passing before his eyes. He had peculiar, set, ways of throwing water about when washing himself; but, in compensation for this, was less obsessed as to

numbers, or as to water dripping, then. For at first the case stood thus: when he hears the number *nine* he must hear *ten* also, or else becomes agitated, "upset," and pained in the head; when washing feels bad unless he hears the water drip a certain number of times; when he hears a ring or knock at the door is compelled to get up and look to see what it is, or else becomes, as he expresses it, "quite bad in the head." Feels depressed, melancholy, confused, worried in mind. Used to feel compelled to use several successive basins of water in washing, even after being well-washed, but not so lately; this he declares was not from any fear of defilement by contact. Is restless, fidgety, and complains of great "nervousness."

In a few weeks, he was removed, being much better; but was re-admitted about nine months afterwards, as being dangerous and perhaps suicidal. He was still phthisical, and the weight was now reduced to 123 pounds. Among the facts stated in the certificates were his groundless statement that he had great knowledge of music; and that he would commit suicide, as he wished to see the Almighty and the devil; that he drank much neat whisky, but could not swallow any until he had run upstairs and looked through a particular window; that he assaulted a clergyman who called, swore he would pull the house down, tore off the banister, handed his brother a poker and asked him to kill him. Believed that nothing could be done with one hand only, in his presence, and that if it be attempted the other hand will start up and injure him, therefore when being examined made the doctor hold the stethoscope with both hands. Refused food, was violent and threatened to kill others. Would sit or lie for hours in certain postures; and would call his sister up at all hours of the night to place both of her hands on particular objects in the room.

On re-admission.—Extraordinary demeanour, flings himself on the sofa, and tries to kiss the medical officer; goes through odd useless movements and antics; threatens when offered a cup of tea; makes reckless self-contradictory statements. Says he is rotten, that the attendant is his Saviour; asks for poison in order to die; breathes faster when stethoscoped, on the obsession that, if he don't, he won't get what he asks for. Is still disturbed in mind about numbers as before. If one near him puts out one hand only, he becomes uneasy, thinks the unmoved hand would shoot out at him; and his mind dwells upon this.

At times he was extremely irritable, unreasonable, re-iterative, ill-tempered, raspish, discontented, intolerable, and making threats of suicide if he did not get his own way. The same ideas as before about the second hand flying up to strike him; the same mental disturbance and anxious tumult if he does not hear the sixth drip of water follow the fifth; the same illusions as to hearing knocks and people addressing him, and thereupon compulsion to go to seek, at the door, persons whom he never finds. At meals he got up every two or three minutes to look under tables, chairs and plates, and behind doors; and if the door thitherward was not locked, would also, then, go upstairs to look under the beds.

After about 18 months he was removed; but to the last he was irritable, changeable in his views, self-contradictory in statement, suspicious, querulous; and at times deluded that his food was tampered with or altered. Fancied he heard rapping noises upstairs, and felt under compulsion to go up and see what might be there.

Subsequently, he died of phthisis in an infirmary; and whilst there was so excessively querulous and given to outbursts of such bad uncontrollable foul language, and outrageous temper, that the nurses gave him the name of being the most trying and foul-mouthed patient they had ever had the misfortune to nurse in the infirmary (coprolalia).

Other members of the family evinced the indications of hereditary mental degeneracy; and after the patient's death it was found that one of them had induced him to leave all his money to that particular member, who had not any special claim on him, but who pandered to his wishes in order to secure a mean advantage.

III.

Cases Illustrating the Relations of the Mildly to the Dangerously Impulsive Obsessions.

Case 4.—Male, aged 43, of no occupation; he had been taken off the streets by the police, and nothing was known as to his previous history, but he was stated not to be suicidal, epileptic or dangerous. According to the medical certificate, he stated that he heard the Saviour and His disciples tell him there was no hope for him, and had heard people talking about murdering him; and he was said to

have been noisy, excited, violent, at the infirmary whence he was admitted.

Being out of work and short of food, he had wandered in the streets. There he said he had heard heavenly music in the air and voices from Heaven declaring he would go to hell, this being followed by what, as he described it, seems to have been a convulsion with consciousness. Later on, at the infirmary he saw big ugly figures with lights in the eyes; thought he had got to hell, smelt the brimstone, and saw coffins there.

He was very restless, nervous, peculiar. Had recurring fright, and to check this and prevent himself from sinking to the floor and to get rid of the idea of the relics of the fright, he had to turn his eyes and mind on some object near by. He had phymosis; denied ever having had coitus, or having ever masturbated. Had occasionally a bad smell, lasting a second or two. The birds tell him whatever he thinks, and prompt him to do as he does; he sees transparent forms when he is depressed, sees them usually by night, and they prevent sleep, but sometimes by day. Ghost-like forms float before him at night.

He stated that he had been very nervous since being startled and shaken, by someone suddenly putting a hand through a workshop window, near him, when he was at work; and he had been in difficulties ever since, for the more he nerved himself up to meet trouble the more he broke down, and, therefore, had to dodge "trouble." He has been subject to sudden "nervousness, as if the cords of the nape contracted, the nerves of the forehead gave way, and there was a heat to the head, a jumping of the heart, and a confusion in the mind." This condition takes him especially, or more irresistibly attacks him, when he is in low health, or despondent; and, if attacked then, he may fall; but if attacked when in good health he can draw himself together by a determined effort to take the mind off the subject. At times he gets "an irresistible impulse" that to get rid of a feeling of nervousness he "must change the mind," *i.e.*, turn the mind to something else, do something, think of something else, it don't matter what; and that if he don't change the mind in some such way he will get all sorts of foolish thoughts in the mind, and feel agitated and confused mentally. These imperative conceptions, and the simple imperative acts they led to, were very marked.

For a time, he was very depressed, nervous and anxious-

looking; thoughts about troubles and ghosts would come into and torture his mind. He frequently, in *quasi*-seizures, felt compelled to walk very energetically to avoid "going mad and doing something desperate."

Eventually he recovered.

Case 5.—Male, single, had been trained as a musician; admitted, on the first occasion, at the age of 21; the attack of then-existing mental disease being said not to be the first, and to be of about two years' duration. He had notions that family quarrels are necessary and healthful recreations; he connected past and present facts which had no relation to each other; expressed the delusion that a young woman had fallen in love with him, wandered about after her, went frequently to the outside of her home, and on one occasion accosted and annoyed her when she came out, so that she gave him into custody. Towards his brother he showed baseless prejudice, animosity, and violence. Fits of gusty passion had occurred; *e.g.*, one of his brothers gave another a watch, whereupon the patient attacked the giver and cut him through the cheek.

On admission was childish; and incoherent at times; thought his brother was jealous of his height, that he had been placed under care to be made ashamed of himself, and that there will be "a jolly lark over it" when he returns home; that a girl at whom he winked in the street came to his father's shop on purpose to see patient, or else because her father, driving by, noticed patient. That she wished to marry him, he concluded because she ungloved her hand in the shop. At times he said he was placed in the asylum because her father died.

Being removed by his friends to his home, after being upwards of a year under care, he was brought back in two days, having, under a destructive impulse, completely wrecked his bedroom and furniture during the night preceding his readmission.

Next year, he was worse, walked and sat alone, muttered to himself occasionally, became suddenly and impulsively noisy, shouting excitedly, jumping on a chair, or throwing himself prone on a garden path and spitting on a stone. His habits were "dirty"; he lost flesh, had moist and clammy skin, masturbated much. Under various measures of treatment he gradually improved.

Next year, was at times making constant inarticulate purring sounds, nodding the head rapidly in circular move-

ment, and at these times ran about so much and impulsively that a special attendant had to take charge of his exercising, as it was not safe to let him go about among the other patients in the garden. A year later on he was at times laughing childishly and caressing other patients; at other times silent, depressed, taciturn. He was often sleepless and restless.

Improving somewhat, he was taken home for nearly two years; but was brought again, having been impulsively violent and destructive. He was forgetful, gave silly reasons for his acts, made shallow absurd remarks, and in manner and appearance was simple and foolish. He indulged in arm-waving and facial grimaces, and muttered much to himself.

Later on, the impulsive outbreaks became more frequent and dramatic. Sometimes they were sudden impulsive attacks on attendants, made without any warning or overt reason; sometimes the acts consisted of violence to surrounding inanimate objects, such as the smashing of crockery-ware with the fist, the breaking of windows, looking-glasses, chairs, or the pulling down of gas-jets and globes; and in doing so he often injured his hands. When these destructive impulses were prevented from being carried into execution, he turned upon and expended the impulsive eruption on the person thwarting the destructive rage. Facial contortions and grimaces, and peculiar tricks of action, all bore a compulsive imperative appearance.

He often stood, stupidly muttering and talking to himself, making a series of monotonous gestures and grimaces. The habits were "wet and dirty"; cardiac and valvular disease (aortic stenotic) also existed. On one occasion he broke a man's clavicle in an impulsive outbreak; on another he wrecked the furniture of a room.

He cannot give any accurate account of himself; is careless and off-hand in replies, prefers not to know the true answer to any question. Is devoid of interest in anything and of affection, does not care to occupy or amuse himself in any way, although he often plays the piano and this is apparently the one exception to the statement just made. He is most easily led by suggestion to make almost any assertion and to contradict himself at every second sentence. He is the most superficial of shallow personages, and many of his statements are palpably absurd and ridiculous.

When walking with his attendant he often exhibits very

mild forms of obsession; *e.g.*, in walking around on a rectangular path he regularly starts off to doorways at each of two of the angles, makes a stooping movement, then turns sharply, and comes back to rejoin the attendant. But when others are standing at such corner he looks in the direction in which his usual excursus is made, but the pre-occupation of his route arrests the obsession-act for that term. Also, at times, he will suddenly make several half-circular movements with one leg, or hop several times on one leg and then on the other, and this with all the characters of an impulsive act based on an imperative or impulsive idea. At such times he also makes incoherent impulsive utterances, apparently speech-obsessions (onomatomania) then exist.

In the severe and desperate impulsive acts of violence, he spits furiously as if by a *convulsive tic*, and utters impulsively, uncontrollably and consciously a set of foul and abusive words—as if directed at the persons holding and controlling him, or attempting to do so. But the same, or similar, foul words are repeated not only at the time but on each successive occasion, and the utterances are compelled by the paroxysmal morbid impulsive activity—in a word are the outcome of obsession.

IIIA.

Case linking obsessions with impulse in insanity of more common type.

Case 6.—Male, 42, married; bootmaker. From a previous attack of insanity he suffered a year before, for which he was three or four months in an asylum, and was alleged to have recovered. This attack's cause was stated to be unknown, and its duration one week. He had been married nine years without children.

The medical certificate stated that he says he don't feel clear in himself; feels as if he would fall down when he is walking, and that lately whilst riding outside a tramcar he had a very strong impulse to throw himself off, and that he had a feeling continually coming over him to commit suicide if the means were handy. Also that he sits moping in corners, crying for hours, and is generally depressed. He continued to mope, cry, and have suicidal tendencies. He was nervous, shaky, but had not drunk alcoholic fluids for a year and a half, he said, although he formerly took too much

for some years. He admitted self-abuse when young, wet dreams afterwards; and thinks since his marriage there has been sexual marital excess, as he sometimes had coitus three or four times a week and felt worse after it. He and his wife were a mutually uxorious couple.

He was nervous, fidgety, was somewhat deaf and affected with tinnitus, both especially in the right ear. He said he had (on this latter occasion) returned to the workhouse because he was afraid of a knife or hammer lest he should injure himself or others with them. "A nasty feeling comes over him; the noise in his head, and the noise, even in a quiet ward, work him up to be very nervous, excited, as if he would throw himself down to get out of the noise." This state, he says, is not put on him by other people, but comes of itself, and not in consequence of any wrong-doing of his. Says he feels "worried, restless, and uncalm." He cannot account for this except by the noise in the ears—the hissing, rushing, or bell sounds there—but adds that he is probably in this way owing to self-abuse in youth and that his low spirits and worry are due to his own fault. After being talked to, the sound of the speaker's voice seems to ring in his ears. Before he left home was always thinking he smelt fire. Owing to an injury at the age of five years, he had lost the sense of smell in the left nostril. The sensorial perversions appeared to be limited to hearing and smell, chiefly; but sparks before the eyes were also complained of.

The impulses were worse indoors than out, and bore some relation to the size of building he was in (claustrophobic element). A creepy feeling pervaded the scalp, and when his head was tapped by finger-tips it sounded hollow to him. Frequently felt he must attack and injure those around him; as well as having frequent impulses to suicide; and would do these deeds in any way he could get the chance to.

Two weeks later on, there were bad tastes in the mouth, a humming noise in the head, occasional feelings of faintness and feelings of being "heavy-headed" or "thick-headed." He declared that indecent thoughts were put in his mind by others around him; a statement for which there was no objective basis; and he still suffered from impulses of violence to others.

The impulses to attack others were extremely strong and almost uncontrollable, so that sometimes his hands actually

moved to strike someone, and could not be altogether checked.

At times he complained of terrible noises continually in his head, aggravated by any sound made in his hearing.

The frequent impulses to homicide continued, but he wished to avoid the disgrace he would bring on his family by doing "a murder;" for often he suffered the dreadful feeling, thought and compulsion to injure or kill someone. Treatment of various kind was tried with some improvement to the state; but the depression, the dreadful feelings, and the imperative conceptions to bite or injure or kill someone did not cease, although lessened; his look was often pale, agitated, distressed, and he frequently besought to be shut up, put away, or isolated, lest his impulse to kill should be effective. Under treatment he gained weight.

Eight months after admission he was removed.

IIIb.

Case linking obsessions with convulsive tic in paranoia.

Case 7.—Male, single, aged 55, member of the legal profession. He had for some time been under care in a public asylum, on a former occasion, but although liberated therefrom had never recovered, and rapidly deteriorated into a totally incurable state when left to his own devices and control. One of the results of his being so left was the excessive use of tobacco, which was one of the alleged causes of the condition for which he came under my care, the other alleged cause, namely, "over-study," being one for which there was no real ground, although his fitful spurts of mental work, no doubt, were not improving to the mental state. He lived by himself in untidiness, disorder, and dirtiness; until one day, when he issued forth on the street with his trousers undone, was told of this by a passer-by whom he at once knocked down, as he did also a policeman who came to arrest him. He was then taken in charge by the police, found to be insane, and was put under care and control under the lunacy law.

The certificates under which he was admitted, described his delusions of conspiracy against him by his relatives and others, including a public body governing a town, to deprive him of the means of existence, and prevent him from following his profession; also of his being followed about and watched, and the sale of refreshments to him pre-

vented; and that, if rich, he would have been murdered by, or at the instigation of, the same persons. Also that a sum of money had been demanded from him, for rent, which had reference to the numbers on some Assyrian and Egyptian stones. The certificates also described his inability to give a correct account of himself, his general neglect of personal appearance, his slovenly, dirty ways, aptness to partly undress in public, his fits of laughter interrupting his recital of events, his absence of self-respect, his general restlessness and his previous acts of barricading the house in which he lived, and of arming himself with firearms against imagined attack.

On admission he was in the same general mental state as just cited from the certificates; besides which his convulsive fits of violent paroxysmal *spitting, hawking, and snorting* were noticeable; these were quite uncontrollable, were associated with momentary mental excitement, and increase of irritability.

Several months afterwards he was still very troublesome, being very untidy, slovenly and self-neglectful in his inclinations, and resistive and resentful towards the necessary operations of being cleaned, and made and kept tidy (or rather as little dirty and untidy as possible). As he would not do these operations for himself, they had to be done by attendants, and the touching of him, for such purpose, he denounced as an assault. He still often stamped about in paroxysms, snorting, or hawking, or spitting, or doing two, or all three of these loudly, uncontrollably, and apparently under great mental excitement; also swearing and muttering much to himself, and annoying those about him. In consequence of his solicitor having given him a copy of an affidavit which it became my duty to make about him, he became very bitter and abusive towards me; and on one such occasion, when thus excessively abusive and possessing little self-control, he began to proceed to physical violence. He was often restless and noisy at night.

Later on he would frequently open conversation with me by abrupt reference to conspiracy against him, on the part of his relatives, his utterances being rapid and disconnected. The memory was impaired. He was often restless, walking up and down hastily, sniffing, snorting, blowing through the nose, paroxysmally, in a peculiar way characteristic of him, talking angrily to himself and overturning and tossing about books and newspapers. He was querulous,

and made trumped-up charges about the necessary personal care and attention he received; none of which latter he desired, being still regardless of cleanliness and personal appearance; and manifesting filthy habits and eccentric ways. He still declared his relatives were plotting against him and squandering his money.

Three years after admission he told me in one conversation that, a number of years before his admission, he had had the delusion that "it was all nonsense about their killing the Abyssinian king, and what it was alleged, in the newspapers, they were doing there, that in fact it was a trick they were playing" to deceive the public—also that a certain ordinary policeman was an old friend of his, a somewhat distinguished man. He alleged that he had been driven insane—"tormented into it." He was still inclined to be—if he could get the chance—very untidy, dirty, restless; occasionally stamping up and down furiously, either indoors or in the grounds, snorting violently, muttering and talking as if denouncing or addressing persons not present. He stated that he was in a frightful position, his relatives and others continually "pressing upon" him, or "keeping up a pressure on" him; that certain relatives (named) have had him put under control, partly in order to possess themselves of his money, partly to get him out of the way, and partly "for cruelty and spite." He alleged, delusionally, that the town treasurer of G—— had told the people near patient's London abode that he was mad, so that he had been continuously watched about the neighbourhood, and such a burden and pressure was kept upon him that he could not follow his profession, and so that he was, practically, kept out of it; that he could not get his money, and had always been kept out of it and told that he was a blockhead; and that a man watched him all the way on a journey of several hundreds of miles he made to London. Yet he admitted that he had been out of his mind once or twice; as, *e.g.*, when he had said that some stranger was Sir ——, a neighbour of his.

Shortly after this he was removed, relieved.

IX.

THE CLINICAL PHENOMENA OF OBSESSIONS.

I think the best description, and the earliest full one, of some of the forms of obsession is that by George Borrow in the pages of *Lavengro*; and never since I read it with the

fascination of boyhood has the memory of the wonderful delineation faded altogether. Nor is it without surprise one does not find it quoted in medical writings on the subject.

Borrow was a Prince among the English Romancers. He wrote from nature with marvellous fidelity and force. *Lavengro* was published in 1851, and contains a description of some obsessions, which, although not absolutely the earliest, was the earliest of any fulness or of masterly kind. Moreover, I believe that in it, and under the guise of different personages in the romance, he described his own case. How else, at that time, he could have obtained so conspicuously accurate and clear a knowledge of the condition it would be hard to say. It is one of the exceedingly few examples of mental abnormality accurately portrayed in works of fiction; it is a cry from the deep waters of affliction; a marvel of self-representation fashioned in the fire of suffering.

Borrow lived the life of a solitary recluse and wanderer. He was usually termed "eccentric;" as such he was described by some of my relatives who knew him. In my youth a projected interview with him on a subject of mutual interest was not carried out.

On grounds which cannot be discussed here, I think that, under the title *rôle* of *Lavengro*, Borrow describes some of the phases of obsession in his early life; under the guise of the elderly literary personage, some of the phases coming on in his later life. Besides the obsessive, the neurasthenic, melancholic, hypochondriacal, and other, elements are strongly depicted.

In the order of succession just referred to they are described as follows:—

"A lover of nooks and retired corners, I was as a child in the habit of fleeing from society, and of sitting for hours together with my head on my breast. What I was thinking about it would be difficult to say at this distance of time; I remember perfectly well, however, being ever conscious of a peculiar heaviness within me and at times of a strange sensation of fear, which occasionally amounted to horror, and for which I could assign no real cause whatever. By nature slow of speech, I took no pleasure in conversation nor in hearing the voices of my fellow creatures. When people addressed me I not unfrequently . . . turned away my head from them and if they persisted in their notice burst into tears. . . ." (There is then an account of seizing, at

the age of three years, a viper which permitted him to do so; and of convulsions and unconsciousness from eating poisonous berries). . . . "I loved to look upon the heavens, and to bask in the rays of the sun, or to sit beneath the hedgerows and listen to the chirping of the birds, indulging the while in musing and meditation as far as my very limited circle of ideas would permit."

A book is sent to him as a present, and before he knows what it is like "all at once a strange sensation came over me, a singular blending of curiosity, awe, and pleasure" which he refers to those more secret and mysterious nerves in which he has a notion "the mind or soul has its habitation, which . . . occasionally tingle and vibrate before any coming event closely connected with the future weal or woe of the human being." The book turned out to be *Robinson Crusoe*, and the previously listless, pondering child was soon cantering before a steady breeze over an ocean of enchantment.

There are other references; but we hasten on to Lavengro at the age of 16, and the choice of a profession for him.—His erratic courses; such as forsaking the study of Greek for that of the Irish tongue; the study of Italian and the Divine Comedy for Rommany and its gipsy lore; placed difficulties in the way of choice. But now "my strength and appetite suddenly deserted me, and I began to pine and droop . . . and was soon stretched upon my bed, from which it seemed scarcely probable I should ever more rise. . . . I made up my mind to die and felt quite resigned." . . . A favourable change occurred. . . . "I had become convalescent it is true, but my state of feebleness was truly pitiable. I believe it is in that state that the most remarkable feature of human physiology frequently exhibits itself. Oh, how dare I mention the dark feeling of mysterious dread which comes over the mind, and which the lamp of reason, though burning bright the while, is unable to dispel! Art thou as leeches say, the concomitant of disease—the result of shattered nerves? Nay, rather the principle of woe itself, the fountain head of all sorrow co-existent with man . . . and woe doth he bring with him into the world, even thyself, dark one, terrible one, causeless, unbegotten, without a father. . . . How sentient is the poor human creature of thy neighbourhood! how instinctively aware that the flood gates of horror may be cast open and the black stream engulf him for ever and ever.

"What ails you my child?" said a mother to her son, as he lay on a couch under the influence of the dreadful one; "what ails you? you seem afraid!"

Boy.—And so I am; a dreadful fear is upon me.

Mother.—But of what? There is no one can harm you; of what are you apprehensive?

Boy.—Of nothing that I can express; I know not what I am afraid of, but afraid I am.

Mother.—Perhaps you see sights and visions. . . .

Boy.— . . . Mine is a dread of I know not what, and there the horror lies.

Mother.—Your forehead is cool and your speech collected. Do you know where you are?

Boy.—I know where I am and I see things just as they are . . . and that there is no ground for being afraid. I am, moreover, quite cool and feel no pain. . . ."

* * * * *

Time goes on, and, on a walking tour, he meets a learned stranger at an inn who makes certain movements and touches, by obsession, when certain ideas are broached, or rise by association, during conversation. *E.g.*, he suddenly rises from his chair, walks to the mantel-piece, is motionless for a while, then raises his hand, touches the mantel-piece, and returns to his seat. Or he furtively touches a glass or a fork on the table. Or (meeting in it certain expressions like his own) he dashes the newspaper he is reading to the ground, and stoops to pick it up, moving his forefinger along the floor and slightly scratching it with his nail. Whereupon, "'Do you hope, sir,' said I, 'by that ceremony with the finger to preserve yourself from the evil chance?' The stranger started." . . .

The stranger—reserved, learned, wealthy—invites the wanderer to his home, where he touches objects when certain ideas are broached or recur—*e.g.*, when "the dark hour" is mentioned—in order to stay the evil chance: and admits that he quakes at some *ideas*.

Then he tells the story of his life.—His grandfather a prosperous country gentleman, who died of apoplexy. His father, the only child, and born after many years of his parents' wedlock, and to a good fortune and comfortable outward surroundings; yet often a curser of his fate. The reciter himself, a posthumous child, and prematurely born owing to his mother's shock on the sudden death of his

father by accident. He warns that his life has been one of wild imaginings and strange sensations, that he was born with excessive sensibility which has been his bane. No one is fortunate unless he is happy; but "no sooner has my imagination raised up an image of pleasure, than it is sure to conjure up one of distress and gloom; these two antagonistic ideas instantly commence a struggle in my mind, and the gloomy one generally, I may say invariably, prevails. How is it possible I should be a happy man?"

It has invariably been so with me from the earliest period that I can remember; the first playthings that were given me caused me for a few minutes excessive pleasure; they were pretty and glittering; presently, however, I became anxious and perplexed, I wished to know their history, how they were made, and what of — were the materials precious?" . . . and soon the playthings were broken "in an attempt to discover what they were made of."

When I was eight years of age my uncle . . . sent me a pair of Norway hawks. . . Oh, how rejoiced was I with the present which had been made me . . . I would have a house of hawks; yes, that I would—but—and here came the unpleasant idea—suppose they were to fly away, how very annoying! Ah, but, said hope, there's little fear of that, feed them well and they will never fly away . . . so sunshine triumphed for a little time. Then the strangest of all doubts came into my head; I doubted the legality of my tenure of these hawks; how did I come by them? Why, my uncle gave them to me, but how did they come into his possession? what right had he to them? after all, they might not be his to give.—I passed a sleepless night. The next morning I found the man who brought them. 'How came my uncle by these hawks?' I anxiously inquired.—'They were sent to him!' . . . 'And who sent them?'—'I don't know.' Nor could his uncle have satisfied him . . . it is true he could tell who sent him the hawks, but how was he to know how the hawks came into the possession of those who sent them to him, and by what right they possessed them or the parents of the hawks . . . "and I believe no title would have satisfied me that did not extend up to the time of the first hawk, that is, prior to Adam, and could I have obtained such a title, I make no doubt that, young as I was, I should have suspected that it was full of flaws. Disgusted with the hawks, and no wonder, seeing all the inquietude they had caused me; I soon totally

neglected the poor birds. . . . My uncle soon sent me a fine pony ; at first I was charmed with the pony, soon, however, the same kind of thoughts arose which had disgusted me on a former occasion. How did my uncle become possessed of the pony ? This question I asked him the first time I saw him. Oh, he had bought it of a gypsy, that I might learn to ride on it. A gypsy ; I had heard that gypsies were great thieves, and I instantly began to fear that the gypsy had stolen the pony. . . . I instantly ceased to set any value upon the pony. . . . Had I looked upon my title as secure, I should have prized it so much that I should scarcely have mounted it for fear of injuring the animal ; but now, not caring a straw for it, I rode it most unmercifully” . . . but once, as he rode it furiously, the pony flung him ; and it was many months before he recovered from the desperate contusions received.

His mother falls ill, the thought that he might possibly lose her rushes into his mind for the first time, “it was terrible and caused me unspeakable misery, I may say horror. . . . I rested neither day nor night, but roamed about the house like one distracted. Suddenly I found myself doing that which even at the time struck me as being highly singular. I found myself touching particular objects that were near me, and to which my fingers seemed to be attracted by an irresistible impulse. It was now the table or the chair that I was compelled to touch ; now the bell-rope ; now the handle of the door ; now I would touch the wall, and the next moment stooping down, I would place the point of my finger upon the floor : and so I continued to do day after day ; frequently I would struggle to resist the impulse, but invariably in vain. I have even rushed away from the object, but I was sure to return, the impulse was too strong to be resisted : I quickly hurried back, compelled by the feeling within me to touch the object. Now, I need not tell you that what impelled me to these actions was the desire to prevent my mother’s death ; whenever I touched any particular object, it was with the view of baffling the evil chance, as you would call it—in this instance my mother’s death.

A favourable crisis occurred in my mother’s complaint, and she recovered ; this crisis took place about 6 *a.m.* ; almost simultaneously with it there happened to myself a rather remarkable circumstance connected with the nervous feeling which was rioting in my system. I was lying in bed

in a kind of uneasy doze, the only kind of rest which my anxiety, on account of my mother, permitted me to take, when all at once I sprang up as if electrified, the mysterious impulse was upon me, and it urged me to go without delay, and climb a stately elm behind the house, and touch the topmost branch; otherwise—you know the rest—the evil chance would prevail. Accustomed for some time as I had been, under this impulse, to perform extravagant actions, I confess that the difficulty and peril of such a feat startled me; I reasoned against the feeling, and strove more strenuously than I had ever done before; I even made a solemn vow not to give way to the temptation, but I believe nothing less than chains, and those strong ones, could have restrained me. The demoniac influence, for I can call it nothing else, at length prevailed; it compelled me to rise, to dress myself, to descend the stairs, to unbolt the door, and to go forth; it drove me to the foot of the tree, and it compelled me to climb the trunk; this was a tremendous task, and I only accomplished it after repeated falls and trials. When I had got among the branches . . . the ascent was not so difficult. . . . As I approached the top, however, the difficulty became greater, likewise the danger; but I was a light boy, and almost as nimble as a squirrel, and, moreover, the nervous feeling was within me, impelling me upward. It was only by means of a spring, however, that I was enabled to reach the top of the tree; I sprang, touched the top of the tree, and fell a distance of at least twenty feet, amongst the branches; had I fallen to the bottom I must have been killed, but I fell into the middle of the tree, and presently found myself astride upon one of the boughs; scratched and bruised all over, I reached the ground, and regained my chamber unobserved; I flung myself on my bed quite exhausted; presently they came to tell me my mother was better—they found me in the state which I have described, and in a fever besides. The favourable crisis must have occurred just about the time that I performed the magic touch; it certainly was a curious coincidence, yet I was not weak enough, even though a child, to suppose that I had baffled the evil chance by my daring feat.

Indeed, all the time that I was performing these strange feats, I knew them to be highly absurd, yet the impulse to perform them was irresistible—a mysterious dread hanging over me till I had given way to it; even at that early period I frequently used to reason within myself as to what could be

the cause of my propensity to touch, but of course I could come to no satisfactory conclusion respecting it; being heartily ashamed of the practice, I never spoke of it to any one, and was at all times highly solicitous that no one should observe my weakness."

Living with his mother in the greatest retirement in the country, pursuing studies under tutors, roaming the woods and green lanes, occasionally fishing or hunting; and yet not happy, for a continual dread of his mother's death overshadowed his mind;—time went on until he had come of age. Then his uncle takes him in hand, introduces him to town life and gaieties, and he becomes "moderately dissipated." And so it goes on for four years, until one morning, with a very serious look, his uncle announces to him "'your mother is very ill.' I staggered, and touched the nearest object to me; nothing was said for two or three minutes, and then my uncle put his lips to my ear and whispered something. I fell down senseless. My mother was ——. I remember nothing for a long time—for two years I was out of my mind; at the end of this time I recovered, or partly so."

He now travels abroad for several years, regains tranquillity of mind, returns home, is kindly received by his uncle, lives for a while a life of fashionable dissipation. Tiring of this, he retreats to his estate in the country, where, for at least ten years, he passes a regular country life, not without some society and occupation of his time, and is seldom or never visited by the magic impulse. But finally,

"I started out of bed one morning in a fit of horror, exclaiming, 'Mercy, mercy! what will become of me. I am afraid I shall go mad. I have lived thirty-five years and upwards without doing anything; shall I pass through life in this manner? Horror!' And then in rapid succession I touched three different objects."

He determines to set about something; feels a craving to distinguish himself; takes it as intended to rouse his undiscovered latent powers; these he seeks to discover by trying many studies; by accident he finds he has a ready pen and teeming imagination, and becomes an author. His first book appears.

"The public were delighted with it, but what were my feelings? Anything, alas! but those of delight . . . my perverse imagination began to conceive a thousand chimerical doubts; forthwith I sat down to analyse it; . . . to be brief,

I discovered a thousand faults in my work, which neither public nor critics discovered. However, I was beginning to get over this misery, and to forgive my work all its imperfections, when—and I shake when I mention it—the same kind of idea which perplexed me with regard to the hawks and the gipsy pony rushed into my mind, and I forthwith commenced touching the objects around me, in order to baffle the evil chance, as you call it; it was neither more nor less than a doubt of the legality of my claim to the thoughts, expressions and situations contained in the book; that is to all that constituted the book. How did I get them? How did they come into my mind? Did I invent them? Did they originate with myself? Are they my own, or are they some other body's? You see into what difficulty I had got; I won't trouble you by relating all that I endured at that time, but will merely say that after eating my own heart, as the Italians say, and touching every object that came in my way for six months, I . . . flung . . . the copy of my book which I possessed, into the fire, and began another.

But it was all in vain; I laboured at this other, finished it, and gave it to the world; and no sooner had I done so, than the same thought was busy in my brain, poisoning all the pleasure which I should otherwise have derived from my work. How did I get all the matter which composed it? Out of my own mind, unquestionably; but how did it come there—was it the indigenous growth of the mind? And then I would sit and ponder over the various scenes and adventures in my book, endeavouring to ascertain how I came originally to devise them, and by dint of reflecting I remembered that to a single word in conversation, or some simple accident in a street, or on a road, I was indebted for some of the happiest portions of my work; they were but tiny seeds, it is true, which in the soil of my imagination had subsequently become stately trees, but I reflected that without them no stately trees had been produced. . . . Thus a dead fly was in my phial, poisoning all the pleasure which I should otherwise have derived from the result of my brain sweat. . . . But, not to tire you, it fared with my second work as did with my first; I flung it aside, and in order to forget it I began a third, on which I am now occupied; but the difficulty of writing it is immense, my extreme desire to be original sadly cramping the powers of my mind; my fastidiousness being so great that I invariably reject whatever ideas I do not think to be legitimately my

own. But . . . I am constantly discovering that . . . I am continually producing the same things which other people say or write . . . you will easily conceive the distress which then comes over me. . . .

For some time past I have given up reading almost entirely, owing to the dread which I entertain of lighting upon something similar to what I myself have written. I scarcely ever transgress without having almost instant reason to repent. To-day, when I took up the newspaper, I saw in a speech of — at an agricultural dinner, the very same ideas, and almost the same expressions which I had put into the mouth of an imaginary person of mine, on a widely different occasion; you saw how I dashed the newspaper down—you saw how I touched the floor; the touch was to baffle the evil chance, to prevent the critics detecting any similarity between the speech of — at the agricultural dinner and the speech of my personage. My sensibility on the subject of my writings is so great that sometimes a chance word is sufficient to unman me, I apply it to them in a superstitious sense; for example, when you said some time ago that the dark hour was coming on, I applied it to my works—it appeared to forebode them evil fortune; you saw how I touched, it was to baffle the evil chance; but I do not confine myself to touching when the fear of the evil chance is upon me. To baffle it I occasionally perform actions which must appear highly incomprehensible; I have been known, when riding in company with other people, to leave the direct road, and make a long circuit by a miry lane to the place to which we were going. I have also been seen attempting to ride across a morass, where I had no business whatever, and in which my horse finally sank up to its saddle-girths, and was only extricated by the help of a multitude of hands. I have, of course, frequently been asked the reason of such conduct, to which I have invariably returned no answer, for I scorn duplicity. . . . I merely did these things to avoid the evil chance, impelled by the strange feeling within me. . . . If I touch various objects, and ride into miry places, it is to baffle any mischance befalling me as an author, to prevent my books getting into disrepute;” to prevent anything in my work resembling aught in any other (abridgment W. J. M.) . . .

“Every now and then my reason tells me that these troubles and anxieties of mine are utterly without foundation; that whatever I write is the legitimate growth of my

own mind, and that it is the height of folly to afflict myself at any chance resemblance between my own thoughts and those of other writers . . . ”

Thus far the host; and the narrative now resumes its usual form, Lavengro again taking up the thread of it, speaking in the first person.

“During the whole night I was acting over the story which I had heard before I went to bed. At about eight o’clock I awoke . . . and whilst dressing I felt an irresistible inclination to touch the bedpost. I finished dressing and left the room, feeling compelled, however, as I left it to touch the lintel of the door. Is it possible, thought I, that from what I have lately heard the long-forgotten influence should have possessed me again? but I will not give way to it; so I hurried downstairs, resisting as I went a certain inclination which I occasionally felt to touch the rail of the bannister. . . . After a stroll of about half-an-hour I returned to the house in high spirits. It is true that once I felt very much inclined to go and touch the leaves of a flowery shrub which I saw at some distance, and had even moved two or three paces towards it; but, bethinking myself, I manfully resisted the temptation. ‘Begone,’ I exclaimed, ‘ye sorceries, in which I formerly trusted—begone forever vagaries which I had almost forgotten.’”

. . . Lavengro’s parting advice to his host is:—“Don’t touch, it is a bad habit.” . . . “I departed; at the distance of twenty yards I turned round suddenly; my friend was just withdrawing his finger from the bar of the gate. ‘He has been touching,’ said I, as I proceeded on my way; ‘I wonder what was the evil chance he wished to baffle?’”

Some time after these incidents, and after working hard on poor, rough fare, and after having nearly died from the effects of a poisoned cake, Lavengro sits in a dingle, upon a stone, nerveless and hopeless, . . . with head leaning on his hand, and so continuing for a long, long time, until the entire hollow was enveloped in deep shade, and all was gloom and twilight in the lower parts of the dingle. “And now, once more, I rested my head upon my hand, but almost instantly lifted it again in a kind of fear, and began looking at the objects before me . . . and now I found my right hand grasping convulsively the three fore-fingers of the left, first collectively and then successively, wringing them until the joints cracked; then I became quiet, but not for long. Suddenly I started up, and could scarcely repress the shriek

which was rising to my lips. Was it possible? Yes, all too certain; the evil one was upon me; the inscrutable horror which I had felt in my boyhood had once more taken possession of me. . . . Every moment I felt it gathering force, and making me more wholly its own. What should I do? resist, of course; and I did resist. I grasped, I tore, and strove to fling it from me; but of what avail were my efforts? I could only have got rid of it by getting rid of myself: it was a part of myself, or rather it was all myself. I rushed amongst the trees, and struck at them with my bare fists, and dashed my head against them, but I felt no pain. How could I feel pain with that horror upon me! and then I flung myself on the ground, gnawed the earth and swallowed it; and then I looked round; it was almost total darkness in the dingle, and the darkness added to my horror. I could no longer stay there. . . . My horror increased; what was I to do?—it was of no use fighting against the horror; that I saw; the more I fought against it the stronger it became. What should I do: say my prayers? Ah! why not? So I knelt down under the hedge, and said, ‘Our Father;’ but that was of no use; and now I could no longer repress cries; the horror was too great to be borne. What should I do: run to the nearest town or village and request the assistance of my fellow-men? No! that I was ashamed to do; notwithstanding the horror was upon me I was ashamed to do that. I knew they would consider me a maniac if I went screaming among them; and I did not wish to be considered a maniac. Moreover, I knew that I was not a maniac, for I possessed all my reasoning powers, only the horror was upon me, the screaming horror! . . . The unutterable fear appeared rather to increase than diminish; and I again uttered wild cries, so loud that I was apprehensive they would be heard. . . . I therefore went deeper into the dingle; I sat down with my back against a thornbush; the thorns entered my flesh; and when I felt them I pressed harder against the bush; I thought the pain of the flesh might in some degree counteract the mental agony; presently I felt them no longer; the power of the mental agony was so great that it was impossible, with that upon me, to feel any pain from the thorns. I continued in this posture a long time undergoing what I cannot describe, and would not attempt if I were able.” . . . At last the horror subsides; returns, but is not so wild as before; subsides, comes again, again subsides: at last

Lavengro falls asleep. . . . Next day, he sat thinking of what he had undergone; "all at once I thought I felt well-known sensations, a cramping of the breast, and a tingling of the soles of the feet—they were what I had felt on the preceding day; they were the forerunners of the fear. I sat motionless on my stone, the sensations passed away and the fear came not. Darkness was now coming again over the earth; the dingle was again in deep shade; I roused the fire . . . and sat for a long time looking on the blaze; I then went into my tent. I awoke . . . about midnight—it was pitch dark, and there was much fear upon me."

A few days later he is "very much afraid"—afraid of the "evil one" who is "coming upon" him: his fear-fits or horror-seizures being personified, as "the evil one."

*The Significance of Weismann's Doctrines in Insanity.** By
GEORGE R. WILSON, M.D.

I. General Physiological Considerations.

"Clearer conceptions of these matters would be reached if, instead of thinking in abstract terms, the physiological processes concerned were brought into the foreground."† From this counsel which Mr. Spencer gave—counsel which disputants have been slow to follow—towards the end of the unsatisfactory controversy which succeeded the translation into English of Weismann's essays, we shall depart as slightly as possible. Yet at the outset we must deal with "abstract terms," in attempting to define the real issue which Weismann has raised; even if, in so dealing with them, I do but demonstrate how much wiser it would be to avoid them.

The controversy, so far as I have been able to follow it, concerns itself with the possibility of the organic transmission of so-called "acquired characters." Weismann was the first to insist upon the distinction between the "hereditary parts" and the "acquired parts" of the organism. Our first business then must be to try to discover the physiological differences which underlie this supposed distinction, and, having done so, I think we shall find it impossible to recognise it as a physiological category at all, and shall be

* Read at the Annual Meeting of the Medico-Psychological Association, 1896.

† *Contemporary Review*, May, 1893.

compelled to admit that the real issue which Weismann's studies has raised has been greatly confused, by his having regarded a fruit of an error in his logic as a real physiological distinction.

This distinction between "inherited parts" and "acquired parts" is not made by Weismann alone, but has been endorsed, more or less explicitly, by Wallace, Romanes, Poulton, Lankester, Ball,* even Spencer, and others. And these acquired characters have to bear the whole brunt of the battle. By one side they are rejected as characters merely acquired, making no contribution to the development of the race, and scarcely to be regarded as part of the person. By the other side they are exalted to the first rank as characters which mark in every generation its advance upon the last. Now, to my mind, the terms imply a distinction which does not exist. It is (to use a simile which embodies a similar misconception) like the distinction between real estate and personal estate. For as there is not really an intrinsic difference between real estate and personal estate, so there is no organic difference between inherited structures and acquired structures.

The difficulty has arisen from our careless use of such terms as "heredity" and "inherited." Having borrowed the terms from civil authorities, scientists have used "inherited" in its civil sense, and speak of structures as being passed on from generation to generation. Such inheritance does not occur in organisms. That baldness which someone "inherits from his mother's side" is not his mother's baldness; the hairs which are not, are not the same hairs whose loss his mother deplored. Structures are not inherited in the sense in which property is. And if the term inheritance makes confusion we ought to employ some other—a term which will signify reappearance, or rather resemblance, and not one which implies actual transference of structure.

It will make our conceptions of this problem clearer if we keep in mind that "Heredity" is an abstract term, and does not describe anything which ought to have a place in a physiology of the organism. Heredity is not a structure; it has no material form. It is not a force (though we speak as if it were); it has no molecular motion. And nothing may be assumed to be a factor in physiology that is not

* That unusually convenient phrase of Mr. Ball's, "use inheritance," and indeed his whole book, *The Effects of Use and Disuse*, exemplify very well the futility of attempting to make this distinction clear.

either a structure or a force. Heredity is a product of logic, a principle, or a law. And the law reads thus: *offspring resembles parent*. Brought nearer to physiology, the law of heredity is that germs of the same race, developing under the same conditions, manifest the same differentiations. The inference, therefore, for physiology, is that germs of the same race are of similar constitution, and the problem for physiology is to explain this similarity.

We can now see, I think, that the distinction between inherited and acquired structures is not physiological. Every organism inherits from its parent, or, more correctly, begins as, a fertilised ovum—nothing more. The adult characters, in which an organism resembles its parent or its ancestor, are differentiations wrought out in structure as the result of reaction to environmental conditions. So also are acquired structures so called. They too are adult differentiations of the original germ, the results of physiological reactions. And all the difference, so far as I can see, between structures classed as *hereditary* and those which are called *acquired* is that the former are physiological reactions to familiar and usual environmental conditions, while “acquired” structures are reactions to new or unusual conditions. We may take examples of this distinction from cerebral physiology, as being pertinent to the special study which we affect, and as illustrating sufficiently the same distinction, as it is supposed to hold good as regards tissues other than nervous.

In mental life, or, in another regard, in cerebral development, a class of differentiations has been insisted upon which are supposed to specially typify structures which are the products of exercise and use. Weismann's essay on Music elaborates this point. Exercise and habit, purposeful practice, and the intelligent pursuit of all branches of music, if persistently persevered in, lead to musical skill. Musical skill then is an acquired character. As such it is to be distinguished from the mental predispositions—interest in sound and in sound-production which made it possible; and such predispositions are presumed to have a physical basis—cortical differentiations, implicitly assumed to exist *ab ovo*, which are “inherited parts.” A little examination will show that this is not a physiological distinction. Stated generally, we may say that the basis of musical skill is a co-ordinate differentiation in the musical centres—auditory and motor primarily, but also in the cells and fibres which represent imagination, feeling, the sense of harmony, and musical

composition. Now if we trace a musician's development we may point out how, at every stage, he was *acquiring* a new musical idea and a new technical power. And so, working backwards, we may whittle away his "characters" until we regard him *in utero* as an organism with, amongst others, the undifferentiated centres for hearing and for moving. But why stop there? A few months previously he had no cortical centres at all. They were "acquired" in his latter months *in utero* as reactions to physiological conditions.

Or again, take the function of speech. Is that inherited or is it acquired? Weismann's answer I think would be that, in so far as speech is a function attained by exercise and use, it falls into the class of acquired characters. But he would probably assume that there were certain hereditary predispositions, or inherited parts, which made the acquisition of speech possible. We may at once admit that as the parent was predisposed to speech so is the offspring. And, in that sense, there is a hereditary predisposition—a predisposition recurring in successive generations. But we may not let pass the implication conveyed in the term inherited or hereditary parts. It is physiology that is wanted, and in the physiology of speech development we shall find it inadmissible to distinguish between acquired structures and inherited structures. Following the same course as in our summary analysis of musical skill, we may trace back the development of speech to the infant's early cries. All of speech that is learned in after life we concur in calling acquired. But why draw the line at all? The simplest mode of speech is reflex speech excited by feeling. A pin prick on the buttock is followed by a cry. Is the nerve-path from the buttock to the cortex and onwards to the vocal cords "inherited"? Surely not. A few months previously there was no buttock, no cortex, no vocal cord. The whole of the speech mechanism has been "acquired" *in utero* as a result of physiological conditions. And in that sense, the only sense admissible in physiology, all differentiations, from the first subdivision of the ovum onwards, are acquired. There is no organ, no structure, which has been differentiated otherwise than by the growth and development of cells, in a nutritive medium, and reaching to mechanical and other excitation. The process which underlies a singer's attainment of great technical skill is in the same physiological class as the process by which the embryo attains to a

group of undifferentiated nerve cells ultimately destined to become Broca's convolution.

If we allow that the distinction between acquired and inherited parts is impossible, the issue which Weismann has raised becomes at once wider and simpler. We revert to the physiological statement of the law of heredity: germs of the same species, developing under constant conditions, manifest similar differentiations. The inference is that germs of the same species are similarly constituted. We wish to know how that similarity in the constitution of the germ-plasm is maintained. And, in particular, we wish to know if developments in the individual life have a specific relation to the individual's germ-cells—the germ-cells which are destined to become the beginnings of the next generation. Do these functions which are being developed in the organism from the beginning of its existence and onwards, contribute in kind to his reproductive function? Is there a specific relation, for example, between the ova in a woman's ovary and her cortex, of such a kind that developments in her cortex contribute to analogous developments in the constitution of her ova?

Weismann's answer to these questions is not ambiguous. In a continuous line, he tells us, the germ-plasm stretches through all the generations. The germ of the parent, early in development, is divided, and from that division the germ of the offspring is derived. And so throughout the ages there is continuity of the germ-plasm. That no one will deny. All life is continuous. In every organism, Weismann points out, we must recognise two kinds of substance—the substance of the body-cells, the somato-plasm, and the substance of the germ-cells, the germ-plasm. This also we may accept unconditionally. So far as I have stated it, the distinction between somato-plasm and germ-plasm may be taken as a convenient one for controversial purposes. Germ-plasm is our name for the *essential substance* of ova and of spermatozoa. All the rest of the organism is somato-plasm. But Weismann means much more than that. He again enters the sphere of physiology, and at that point we must begin to hesitate to follow his distinction. The somato-plasm, he says, is amenable to environmental conditions, and differentiates into the adult parts. The germ-plasm, on the other hand, is hid away in physiological conclusion, and remains unchanged and undifferentiated until such time as germination occurs, when it manifests a differentiation

characteristic of itself, and out of all relation to the differentiation of body-cells.

Weismann's "continuity of the germ-plasm" we may then fairly describe as "physiological isolation of the germ-plasm," and, so expounded, his theory must raise strong opposition in our minds. We are asked to believe that, while brain changes are related to changes in the sense-organs, to changes in muscle, to changes in glands, to changes in the blood and elsewhere; and while every other form of tissue has similar physiological reactions and interactions, there is one kind of tissue which is the exception. The ova and the spermatozoa—or rather the germ-plasm, which is their essential substance—have no specific physiological relation with the other tissues.

Weismann, however, qualifies the statement of the absolute isolation of the germ-plasm by an admission which will, I think, satisfy all the demands of physiologists who are not pledged to his theory of hypothetical factors in development. "I am compelled to admit," he says,* "that it is conceivable that organisms may exert a modifying influence upon their germ-cells, and even that such a process is to a certain extent inevitable. The nutrition and growth of the individual must exercise some influence upon its germ-cells; but in the first place this influence must be extremely slight, and in the second place it cannot act in the manner in which it is usually assumed that it takes place. Any change produced will result from the reaction of the germ-cell upon changes of nutrition caused by alteration in growth at the periphery, leading to some change in the size, number, or arrangement of its molecular units. In the present state of our knowledge there is reason for doubting whether such reaction can occur at all; but if it can take place, at all events, the quality of the change in the germ-plasm can have nothing to do with the quality of the acquired character, but only with the way in which the general nutrition is influenced by the latter."

To physiologists, who hold no brief for a theory of development based upon a hypothesis of special agents in the tissues which determine their differentiations, this admission to which Weismann is "compelled" must seem very conclusive. He admits a "nutritive" relation between somatoplasm and germ-plasm, and it leads to "some change in the

* *Essays*, Vol. i, p. 172, *et seq*

size, number, or arrangement of its molecular units." All that we know of nutritive processes teaches us to expect characteristic changes in the molecular constitution of tissues according to the nature of the nutritive plasma or nutritive forces. Probably no one will deny that the nutritive effect on the other tissues of cerebral metabolism is different in kind from the effect of metabolism in muscle, in bone-marrow, or in thyroid gland. And it has at least not been disproved that the nutritive effect upon the germ-plasm of somatic changes is of a kind which is characteristic of these changes. For example, the growth of bone in adolescence may quite reasonably be held to affect the nutrition of the germ-cells specifically. The enormous bone-metabolism must make a great contribution to the nutritive plasma of the germ-cells, and it may be of such a kind as to alter their molecular constitution in the direction of a predisposition to bone-formation. Similarly, cortical developments may, either materially or dynamically, effect a nutritive change in the germ-plasm, which influences its molecular constitution in favour of nerve-plastic "predispositions." Such an influence must of course be "extremely slight." Nor can we suppose it to be very refined. But still it seems not improbable that, in general, somatic changes of a nervous kind contribute to the molecular constitution of the germ-plasm as above indicated. Having regard to all the familiar correlations of the reproductive function, we may affirm that, whether or not somatic changes influence the germ, germ-changes certainly influence the soma. But here again it may be said that these varied manifestations are coincidences, not correlations. But, granting that they are correlations, we are still at a loss. Take a single concrete example, such as an access of poetical excitement in adolescence. Is the cortical basis of adolescent poetry functionally related to the germ-plasm? Weismann, I think, would reply in the negative. All the kind of relation which such developments imply is a relation between the various somatic tissues. The correlation, if it exists, is between the cortical mechanisms and the lumbar mechanisms, and, through them perhaps, with the reproductive organs. But we have still to prove that the relation extends actually to the germ-plasm, the essential substance of the ova and spermatozoa. Such considerations, I think it will be admitted, show the hopelessness of attempting to solve the problem which has been raised by phenomenal demonstration. All

that we can hope for at present is to perceive more clearly what it is that requires explanation, what the real problem is.

II. *Special Physiological Considerations relative to the Development of Insanity.*

Still persisting in our attempt to define the issue physiologically, our next consideration must be to determine the physiological content in what we describe as insanity.

Omitting reference to the environmental factor, we may, in biological terms, describe the organic factors in insanity as (1) Arrest of Development, (2) Excessive Individual Variation, and (3) Defective Regeneration. Of these factors, one may predominate over another in any given case or in any given mental malady.

(1.) *Arrest of Cortical Development.*—Having regard to the development of the various tissues in ontogeny, observing, as we may, a daily addition of layer upon layer of proliferating cells to form the embryonic organs, we may, I think, form some conception of an initial force, or an initial agent, which determines these remarkably adept cell-activities. It matters not whether we think of such a force in terms of Weismann's determinants, Naegeli's idioplasm, Spencer's physiological units, or of any of the very manifold hypothetical agents in theories of development. The fact remains that germ-plasm, to develop with this ordered rapidity, possesses a unique and characteristic molecular activity. "Why," says Weismann,* "does the segmentation of one half of certain eggs proceed twice as rapidly as that of the other half? Why do the cells of the ectoderm divide so much more quickly than those of the endoderm? Why does not only the rate but also the number of cells produced (so far as we can follow them) always remain the same? Why does the multiplication of cells in every part of the blastoderm take place with the exact amount of energy and rapidity necessary to produce the various elevations, folds, invaginations, etc., in which the different organs and tissues have their origin, and from which finally the organism itself arises? There can be no doubt that the causes of all these phenomena lie within the cells themselves, that in the ovum and the cells that are immediately derived from it there exists a tendency towards a determined (I might almost say specific) mode and energy of cell-multiplication."

* *Essays*, Vol. i, p. 30,

This developmental momentum, if the phrase may pass, which determines the "mode and energy of cell-multiplication," varies in different species, in different individuals, and in different tissues. Its existence is a condition of normal development, its failure signifies arrest. In other words, granting normal environmental conditions, arrest of an organ implies a failure in the initial activity of the ovum. Now arrest of an organ as a rule implies a numerical deficiency in cellular elements. An arrested organ is one in which cell-multiplication has failed. But the arrest which we know to be a factor in insanity is not a numerical failing, but a qualitative deficiency in the cells. I believe we do not realise the full significance of the unique nature of cortical development and of cortical arrest. Certainly I think it escapes Weismann. Yet we cannot regard it, so it seems to me, as of less than supreme significance, whether we are interested in the physiology or the teleology of the nervous system.

The following facts, quoted chiefly from Minot, indicate the kind of consideration which demands an important place in our conception of cortical physiology: Cortical cells are developed from *neuroblasts* which are the transformed *germinating-cells* of the medullary wall. "The number of the germinating cells is very large in the human embryo at four weeks." Most of them become neuroblasts. Brain growth subsequently depends on the growth of individual cells rather than on cell-proliferation. The first cell-process, the axis-cylinder process, of pyramidal cells is developed about the second month. This is accompanied by a marked diminution of the cell-body. At $5\frac{1}{2}$ months the cell begins to grow. The nucleus enlarges, as well as the "court" of protoplasm round it. At about the sixth month the cell pushes out into a process at the apex, and also develops short, simple, lateral processes or dendrites. The cell-character then, at the seventh month, is practically the same as at birth. At birth cells may be found in various stages of development, but the most advanced of them differ from cells of the seventh month only in size. Subsequently there is increase of the dendrites or lateral processes, with complex branchings, which form the nerve-fibre plexus.

Granting the possibility of error in certain details, or of new observations which may modify Minot's account of the embryology of the nerve-cell in unimportant respects, the general facts which remain are enough. It would be diffi-

cult to cite another notably plastic system in which the numerical development of its cellular elements is complete at or about the fourth week of intra-uterine life. Even supposing the date to be inexact, the remarkable fact still remains that cell-proliferation in the cortex has ceased before the stage of extra-uterine stimulation and reaction has begun.

The problem which the Weismann controversy has raised may be stated in the question, Do the structural differentiations in somatic development have a direct and specific relation to germ-development? And my present point is that the physiological conditions to be considered in the case of cortical development are not the same as those of other somatic developments. In other tissues, reduplication marks the acme of molecular activity in the cell. At all events, to our gross perception, cell-multiplication, even when it follows exhaustion or barely forestalls degeneration, seems to be a process implying a very much greater activity than any other cell-development. Cell-proliferation, then, may be conceived to mark a stage of unusual importance in the hypothetical relation of somatic development to germ-development. But such cell-proliferation of the nerve-cells in the cortex either as the result of normal or of abnormal processes is unknown in extra-uterine life. If, then, there is a specific contribution from cortical development to germ-development it is of a kind which we may not assume to be similar to any contribution which we may suppose to come from the other systems.

As cortical development is of a unique kind, so also is cortical arrest. That form of arrest which Bevan Lewis has taught us to recognise in epileptic idiocy is but an example of what we may safely assume to be present in all immature and infertile brains. Development, in the cortex, signifies an elaboration of cell-connections, a multiplication of the relational processes of cells. Bevan Lewis has taught us to recognise in the paucity of these processes in idiotic cells an arrest in the development of their relational function. The inference is that they were deficient in that initial activity, that developmental momentum, which was essential to the proper "mode and energy" of mature differentiation.

But arrest does not only occur in idiocy. Logically it must be presumed to occur in all insanities. It represents physiologically what Hughlings Jackson would call the

negative symptom, "the want," in the insane diathesis. The failure in proper control of impulses, the disability which makes it impossible to realise the full consequences of conduct, the lack of complete fellow-feeling, the defective sense of probability—such symptoms as these imply arrest in the cortical elements of the insane. And whether or not we regard the "dendrites" as the essential structures in the mechanism of mature character, such an arrest is a failure of the cortical cells to establish a complete relational function. And what I wish chiefly to emphasise is that, whatever it may be, such arrest is not due, so far as we know, to a deficiency in the *number* of the cortical elements.

(2.) *Excessive Variation*.—The physiology, or the pathology of excessive variation, follows from what has been said concerning arrest.

I only use the term excessive variation in order to bring the subject into the line of the biological point of view. Clinically we know it as eccentricity, excess, extravagance, or perverse genius. It is recognisable in all insane predisposition—an excess of unrelated development, which contributes largely to the ill-balance of the patient's mind. In experience the excessive function not only preponderates over the other functions, but usurps them. A perverted musical genius hears when others see, when others taste, when others smell. To him all feeling has its musical interpretation; all thought and all imagination are expressible in musical terms. The basis of so "hypertrophied" an organ of the mind we must conceive of as chiefly a specialised differentiation of individual cells. Granting, to begin with, a preponderance of initial activity in the auditory centres, their cells and fibres, catching every movement within ear-shot, have pushed hither and thither after a plan of ever-increasing complexity. Gradually, the main paths differentiated, new avenues of relation have been established throughout the whole mechanisms of associated centres.

So far as we know, an excessive development of such a kind does not imply an excessive cell-proliferation. The brain at birth, as it seems to me, must be regarded as an organ which has a definite number of elements capable of functional activity. Excess of this function, then, or of that, depends, not upon an addition to the number of elements in the representative area, but upon the initial activity (developmental momentum) of the elements within

that area. The greater the activity of the cells the more far-reaching will be their processes, and the more penetrating will be the movements which emanate from them; the more complex will be their associations, the larger will be the number of centres which are brought into relation with, and made subservient to, them.

In considering, therefore, the probability of a specific contribution from an excessive development of, say, musical centres to the development of the germ, we have to inquire what kind of influence it would be which would reach the germ-cells from cortical centres whose excess of development was not a numerical excess but rather a dynamical excess.

(3.) *Defective Regeneration.*—In this connection again it is of the first importance to note that the conditions of regeneration in cortical cells and fibres are not similar to those of regeneration in the other tissues. In the cortical areas the factor which we call the trophic influence of nerve-impulses has become supreme. And if it be objected that the difference is only one of degree, I would reply that the difference in degree has become so great as to constitute a difference in kind.

In somatic tissues other than nervous, reparation of exhausted cells or, more correctly, regeneration of degenerated cells, is believed to be by cell-multiplication. In this regard physiological regeneration closely resembles the regeneration of lost parts which affords biologists so much food for thought. Except under extraordinary conditions,* however, such regeneration does not occur in the cortex. The recovery of function following its abeyance in slight exhaustion is by the gradual anabolic metabolism under the ordinary nutritive conditions. But Foster, whose account of cerebral physiology is pre-eminently suggestive, points out† that the nerve-impulses which reach the cells are the chief factor in determining their metabolism. The first condition of activity in a cortical cell is that it shall be receiving a constant succession of mild stimuli from other cells. No matter how much good blood a centre is bathed in, the first condition of anabolic, as of katabolic metabolism, is that it shall be in relation with other centres.

* V. Voit, however, observed restitution of a part of a pigeon's brain which had been removed. Five months later, a nervous mass had been reproduced, consisting of medullated nerve-fibres and nerve-cells. (Landois and Stirling.)

† *Text-book of Physiology*, § 690.

And, as I take it, the trophic connections of the highest centres do not follow so simple a plan as in the lower levels of the nervous system. Every centre in the cortex is probably to some extent trophic for every other centre. And, in particular, the great sensory avenues—the auditory, the visual, and the tactual—are the great sources of trophic influence. Simple regeneration, then, seems to depend upon the accessibility of the cell to these trophic influences, that is, upon the permeability of its relational parts. We further have to consider what in the cortex corresponds to the regeneration of lost parts. All pathologists lead us to believe that a very large number of the cortical cells in the insane are permanently lost by degeneration. The extent of such loss probably indicates an original predisposition which characterises the insane as compared with the healthy. Now, recovery of cortical function, following permanent degeneration, is not by the process of cell-proliferation as in other somatic tissues, but by the establishment of new cortical connections. Cells which were lying fallow, probably in the “embryonic” stage of differentiation, or cells which hitherto have chiefly subserved another function, take up the function of the lost cells. In order to such recovery of function, plasticity in cells is of the first importance. I mean a readiness to differentiate in response to the stimuli which inaugurate their new relational function. So that we may say that regeneration following permanent loss—whether by a gross lesion or by degeneration—depends upon the same condition as simple regeneration following mild exhaustion. That condition is the accessibility of the cell to stimuli.

Defective regeneration, then, may be held to depend originally upon an incapacity of cells for trophic stimulation, that is, upon a defect of relational differentiation; or, in loss by degeneration, upon the incapacity of “fallow” cells to take on a relational function. The question, as regards a specific influence of such a defect upon germ-development, can be stated in terms which will recall our previous statements of the problem. Does such a defect in the cortex, which depends upon an inherent incapacity of the cells for relational differentiations, imply a failure of a specific contribution (that is, a contribution of a trophic kind) to the germ-cells so that germ development is predisposed in the direction of failure of cortical regeneration?

Conclusion.

Obviously the problem which I have tried to state in physiological terms is very abstruse. It will be granted, I think, that it is not capable of phenomenal demonstration. No one expects to demonstrate a mechanism of relation between the cortex and the germ-cell. The solution of the problem must come either by conclusive experiment—and that is well-nigh hopeless—or by logical reasoning.

In the concluding paragraph of his essay on *The Supposed Transmission of Acquired Characters*,* Weismann says: "If, as I believe, these phenomena can be explained without the Lamarckian principle, we have no right to assume a form of transmission of which we cannot prove the existence. Only if it could be shown that we cannot now or ever dispense with the principle should we be justified in accepting it." But such a statement is a quite inadmissible arrogation to his own biological faith of the right to apply the law of parsimony. On similar terms, Weismann's own theory of development would receive scant courtesy. Any of us might with equal justice say: "I refuse to call in the aid of Weismann's *vis a tergo* to explain the development of the individual so long as I can conceive an explanation which fits with my own particular theory." We have not reached that stage in the development of biology when we can look upon organic processes with ideas so clear that we can intelligently refer them all to one supreme principle or law. All that we can do is to take thought about each and to try to account for every process or phenomenon in such a way that our various explanations of various facts will not be contradictory.

I have endeavoured to show grounds for supposing that the relation between the cortex and the germ, if any, is not the same as that between the other somatic tissues and the germ. From our comparison of the physiological conditions arises a very obvious suggestion (and not all that is obvious is untrue)—that is, that while there may be a material contribution of a specific kind from the other somatic tissues to the germ, that from the cortex is probably a dynamical contribution or it is nothing.

In conclusion I should like to emphasise the importance of a factor in the evolution of the individual which Darwin, Spencer, Weismann, and others touch upon, but which, I think, no one sufficiently emphasises and which some writers

* Vol. i., p. 461.

all but ignore. That factor is the evolution of environment. It is generally assumed that with the contradiction of our belief in the organic transmission of acquired characters, our hope for the ultimate destiny of the human species is set aside. For example, Ball* says in his preface, "The sociological importance of the subject has already been insisted on in emphatic terms by Mr. Herbert Spencer, and this importance may be even greater than he imagined.

"Civilisation largely sets aside the harsh but ultimately salutary action of the great law of natural selection without providing an efficient substitute for preventing degeneracy. The substitute on which moralists and legislators rely—if they think on the matter at all—is the cumulative inheritance of the beneficial effects of education, training, habits, institutions, and so forth—the inheritance, in short, of acquired characters, or of the effects of use and disuse. If this substitute is but a broken reed, then the deeper thinkers who gradually teach the teachers of the people, and ultimately even influence the legislators and moralists, must found their systems of morality, and their criticisms of social and political laws and institutions and customs and ideas, on the basis of the Darwinian law rather than on that of Lamarck."

I rather agree with those who, taking human nature as it is, are optimistic enough to think that universal degeneracy is not imminent. If our logic leads us to expect that, so much the worse for our logic. Civilisation is not an affair of yesterday; strong and wise men are still to the fore. It lies with us to explain the survival of the wise and the strong. And the explanation seems to me to be found in great part in the effect on the individual of a constantly evolving environment—taking ordered shape in view of ordered ends. Most important of all, traditional inheritance is within human control, organic inheritance is not. We cannot in the least foresee, much less provide for, the nature of the offspring to be born to us. But we can, almost with exact precision, provide the environment in which the next generation will grow up.

Suppose that histology is our aim. By acquiring pre-eminent skill a man may hope to add to his son's interest in his art. The hope may or may not be delusive. But whether or no his son be a born microscopist, the environment of a fully-equipped laboratory—microtomes, baths, preparations, stains, an expert "boy"—will make him one. With only average ability the son may soon surpass his

* *The Effects of Use and Disuse.*

father in knowledge and in skill. In all departments of life the same holds good. Conversely, a wise environment may cancel a perverse predisposition. The near relations of lunatics have hoped that the taint may be diluted in their offspring if, before children are born, their life has been well-ordered. The hope may or may not be delusive. But even a considerable predisposition to insanity in a child may be cancelled by a careful upbringing, quite certainly, and so, in virtue of his environment, he may evade his inheritance.

Granted then a good environment—a healthy influence from existing institutions, traditions and customs, public opinion and personal teaching—all that is necessary to insure the future of the species is amenability to the influence of the “not ourselves.” In physiological terms—and to the physiology of the subject we must be faithful to the end—the *summum bonum* of individual development is not a great initial activity in this brain-centre or in that, but rather a general plasticity of cortical structure, a capacity for relational differentiation in any or all of the cerebral organs. Training will do the rest.

*Heredity in Mental Disease.** By J. F. BRISCOE, M.R.C.S.,
F.R.G.S.

Mr. Briscoe gave an account of hereditary influences affecting reproductive processes, entering into details relative to syphilis and temperaments. He held that deviation from a normal standard of mind and body must indirectly affect the reproductive processes. He thereafter traced the life history of a typical neurotic in a series of clinical pictures. Mr. Briscoe illustrated his paper by photographs of a skull which he had brought from East Africa. The skull was also submitted for examination, and was described as having belonged to a child six years of age, to be generally five-eighths of an inch thick, with completely obliterated sutures. The whole was porous (osteoporosis), and the new cancellous tissue of a columnar appearance, and superimposed upon the original bone. Mr. Briscoe was of opinion that it might be useful to compare such a cranium with deformed palates in relation to brain growth. The heredity of direct mental weakness was then discussed, and Mr. Briscoe was of opinion that 90 per cent. of the insane have a heredity of insanity.

* Abstract of a paper read at the Annual Meeting of the Medico-Psychological Association, London, 1896.

*The Increase of General Paralysis in England and Wales: Its Causation and Significance.** By R. S. STEWART, M.D., D.P.H. Camb., Deputy Medical Superintendent, Glamorgan County Asylum, Bridgend.

No Disproportionate Increase of Insanity.

The increase of the total living insane in England and Wales during the intercensal period 1881-91 was 15·24 per cent., while the corresponding increase of population was only 11·7.

The proportion of the yearly average of admissions to asylums, etc., in which the attack is stated to be the first, *i.e.*, occurring insanity, which was in the five years ending 1882 3·3 per 10,000 of population (1881), rose in the five years ending 1892 to 3·7 per 10,000 (1891).

These two facts at first sight indicate an increase of lunacy out of proportion to the increase of population, but, as is shown in the *Census Returns*, 1891, Vol. iv., p. 75, the first is sufficiently accounted for by the "accumulation" resulting from the diminution of the "discharge" rate (deaths and recoveries) of asylums from 19 per cent. in the decennium 1871-80 to 17·83 in the decennium 1881-90; and the explanation of the second is to be found in a change of public view which manifests itself in an ever-increasing tendency to remove the insane from the "mass of unregistered lunacy" to "official cognisance" (the proportion of the officially known to the total living insane increased from 86·5 per cent. in 1881 to 89·1 in 1891), and in an increasing disposition to widen the limits of certifiable insanity so as to include forms of aberration, for example cases of mere senile enfeeblement, which formerly did not come within the category of lunacy.

Disproportionate Increase in General Paralysis.

It appears to be beyond doubt that general paralysis (which constitutes roughly about 9 per cent. of all admissions to establishments in England and Wales) is increasing, and at no small rate. Scattered references to this appear more frequently in recent Annual Reports of the Medical

* Read at the Annual Meeting of the Medico-Psychological Association, London, 1896.

Superintendents of English County Asylums,* and, so far as England and Wales are concerned, reliable data are now available in the Annual Reports of the Commissioners in Lunacy for the past fifteen years (1878-92 inclusive). A study of these is very instructive, indicating as they do a tolerably steady disproportionate increase of this type of disease.† Thus the percentage of general paralytics to total admissions has risen from 8 in the five years 1878-82 to 8·6 in 1883-87 and to 8·9 in 1888-92. The disproportion

* From the collective investigation of Tucker (*Lunacy in Many Lands*, 1887) it would appear that this is also occurring in other countries. This investigation, however, is based only upon the personal opinions of Superintendents unsupported by statistics. To the question addressed to the Superintendents of Asylums: "Has general paralysis increased?" 264 replies were received, in 165 instances in the affirmative, 62·5 per cent., and in 199 in the negative, 37·5 per cent. Arranged according to the country to which they apply the numbers of these answers are as follows:—England, affirmative 33, negative 23; Wales, affirmative 0, negative 3; Scotland, affirmative 5, negative 11; Ireland, affirmative 1, negative 14; France, affirmative 22, negative 6; Germany, affirmative 22, negative 3; Belgium, affirmative 1, negative 4; Netherlands, affirmative 5, negative 1; Denmark, affirmative 2, negative 1; Norway and Sweden, affirmative 3, negative 1; Russia, affirmative 3, negative 3; Italy, affirmative 13, negative 2; Spain, affirmative 2, negative 0; Portugal, affirmative 0, negative 2; Austria, affirmative 8, negative 3; Switzerland, affirmative 3, negative 8; United States of America, affirmative 36, negative 15; Canada, affirmative 6, negative 0. From the foregoing it will be observed that with the exception of six countries—Wales, Scotland, Ireland, Belgium, Portugal, and Switzerland—the prevailing impression indicates an increase of this disease among European and English-speaking races.

Scotland has apparently ceased to be one of the favoured nations, the average percentage of general paralysis as a cause of death, according to the Reports of the Commissioners in Lunacy, being, at least as regards males, a steadily increasing one of late years, as is shown in the following table:—

Average for 31 years ending 1888, males 18·3, females 4·5 per cent.

"	32	"	1889	"	18·5	"	4·7	"
"	33	"	1890	"	18·6	"	4·7	"
"	34	"	1891	"	18·7	"	4·7	"
"	35	"	1892	"	18·8	"	4·7	"
"	36	"	1893	"	19·0	"	4·8	"
"	37	"	1894	"	19·2	"	4·7	"

The increase in the Paris Asylum at Villejuif is shown in the following figures, giving the proportion per cent. of general paralytics to admissions:—1882 13·03; 1883 14·75; 1884 11·00; 1885 14·60; 1886 15·45; 1887 19·50. (Arnaud, *Annales Medico-Psychologiques*, July, 1888, p. 86.) A very exhaustive paper by Kraft-Ebing ("Ueber die Zunahme der Progressiven Paralyse, im Hinblick auf die sociologischen Factoren") has been published in *Jahrbucher f. Psychiatrie*, 1895, xiii. Bd., Heft 2 and 3, in which statistics are given that prove beyond question a very largely increased proportion of this disease in Austria, Germany, and Switzerland.

† The total number of general paralytics admitted to establishments in England and Wales during the fifteen years 1878-92 was 18,438, and it is upon the statistics referring to these that this paper is based.

is very manifest when the comparative figures are stated in the following form :—

Percentage increase of average annual admissions of the quinquenniad 1888-92 over the quinquenniad 1878-82: Total admissions 20·5; admissions less general paralytics 19·3; general paralytics 34·6.

What conclusion, even after making allowance for the possibility of greater certainty of diagnosis,* can be drawn from the above than this, that general paralysis is increasing at a rate which is out of proportion to that which applies to other forms of insanity?

Thus much having been admitted, the next question that arises is :—Do the statistics contained in the Reports of the Commissioners afford any clue as to the probable causation of this increase? The following bear more or less closely on the inquiry.

Sex Relation.

The following table represents the proportion of general paralytics per cent. of total admissions for the three quinquennials under review, distinguishing the sexes :—

TABLE I.—Proportion of General Paralytics per cent. of Total Admissions.

Years.	M.	F.	T.
1878-82	12·8	3·3	8·0
1883-87	14·3	3·1	8·6
1888-92	14·7	3·4	8·9

From this it will be observed that while the increase of the last over the first quinquenniad for both sexes is 0·9, that for females is only 0·1, and for males 1·9. In other words, the increase among men is 19 times greater than among women.†

* The argument that those who are ultimately responsible for the diagnosis are more adept of late years, and that more cases than formerly are therefore recognised, has very little, if any, weight; the personnel of the higher medical staff of English Asylums has undergone very little change in the period under consideration, and there is no reason to suppose that the diagnostic capacity has altered materially in such a short space of time as fifteen years. Again if diagnostic ability were greater, the increase ought to apply uniformly to all classes of patients, which is not so, as will be seen later on.

† The disproportionate increase among males is brought out when the figures are given in another form. In the first quinquenniad the sex-proportion among admissions was 3·7 males to one female; in the last it was 4·1 males to one female. This is quite contrary to the conclusion arrived at by Krafft Ebing, whose statistics show an increasing proportion of women attacked.

Social Position.

Lunatics are, broadly, divided into two groups—the private drawn chiefly from the upper and upper-middle classes, the pauper from the lower-middle and lower classes (the latter, except to a very small extent, not being paupers prior to the onset of the mental affection).

TABLE II.—Percentage of General Paralytics to Total Admissions, distinguishing the Sexes and Social Position.

Years.	Private.			Pauper.		
	M.	F.	T.	M.	F.	T.
1878-82	9·7	1·5	5·8	13·5	3·6	8·4
1883-87	11·2	1·2	6·4	14·8	3·5	9·0
1888-92	12·9	1·1	7·4	15·0	3·7	9·1
Increase or decrease between the first and last quinquenniad	+3·2	−0·4	+1·6	+1·5	−0·1	+0·7

The greatest increase takes place among private males and the next among pauper males,* while the proportion among female private patients is actually a diminishing one. The increase in male private patients, it is to be noted further, is a steadily progressive one, but as regards pauper males it is a diminishing one. The most striking feature of the accompanying Chart (Chart I., p. 767), in which these various changes are graphically represented, is the very pronounced contrast between the steadily maintained increase in the proportion of male private patients, and the as steadily maintained diminution in the proportion of female private patients.

Age Relation.

A comparison of the statistics relating to the age-incidence of general paralysis and of other forms of mental disorder reveals certain very noteworthy and significant facts. Owing to a want of correspondence of age-periods only the last two of the three quinquennials are available for the purpose of comparison.

* The very great increase among private males is evidenced by the alteration of the sex-proportion, which in the first quinquenniad was 7·2 males to one female, and in the last 12·5 to one, the corresponding proportion for paupers being 3·5 to one and 3·7 to one.

TABLE showing the ratio (per 10,000) of the yearly average number
 Wales during five years 1888 to 1892 inclusive to the whole
 years 1883 to 1887 to the estimated corresponding Population
 III. General Paralytics; IV. The Proportion (per cent.) of
 number of Patients admitted, arranged according to ages.

				Under 15 years.			15—19.			20—24.			25—34.			
				M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	
Ratio (per 10,000) of all admissions to population				1888-92...	·4	·2	·3	2·8	2·8	2·8	5·9	5·6	5·7	8·3	8·6	8·5
				1883-87...	·4	·2	·3	2·6	2·7	2·7	5·8	5·3	5·5	8·1	8·1	8·1
Increase					·0	·0	·0	·2	·1	·1	·1	·3	·2	·2	·5	·4
Ratio (per 10,000) of admissions exclu- sive of general paralytics to popu- lation				1888-92...	·4	·2	·3	2·8	2·8	2·8	5·8	5·6	5·7	7·2	8·3	7·8
				1883-87...	·4	·2	·3	2·6	2·6	2·6	5·7	5·2	5·5	7·1	7·7	7·4
Increase					·0	·0	·0	·2	·2	·2	·1	·4	·2	·1	·6	·4
Ratio (per 10,000) of general paralytics admitted to popu- lation				1888-92...	...	...	...	...	·007	·003	·072	·050	·057	1·082	·267	·656
				1883-87...	...	...	...	·011	·004	·007	·071	·029	·049	1·000	·270	·620
Increase+ ... ..					...	...	...	...	·003	...	·001	·021	·008	·082	...	·036
Decrease— ... ..					...	...	...	·011	...	·004	...	...	...	...	·003	...
Proportion (per cent.) of general paralytics to total admissions				1888-92...	...	...	...	...	·2	·1	1·2	·9	1·0	13·0	3·1	7·8
				1883-87...	...	...	...	·4	·2	·3	1·2	·6	·9	12·6	3·3	7·7
Increase+ ... ..					...	...	...	...	...	...	...	·3	·1	·4	...	·1
Decrease— ... ..					...	...	...	·4	...	·2	...	...	...	...	·2	...

of: I. All Patients admitted into Asylums, etc., in England and Population at the time of the Census of 1891, and during the five of 1886; II. All Patients admitted exclusive of General Paralytics General Paralytics admitted to the yearly average of the whole

35-44.			45-54.			55-64.			65 and Upwards.			Total.		
M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
11.2	10.5	10.8	11.2	11.4	11.3	11.1	10.0	10.6	11.6	10.2	10.9	5.5	5.5	5.5
10.4	10.1	10.2	10.3	10.1	10.2	10.4	9.2	9.8	9.8	8.4	9.0	5.1	5.0	5.1
.8	.4	.6	.9	1.3	1.1	.7	.8	.8	1.8	1.8	1.9	.4	.5	.4
8.0	9.8	8.9	8.6	10.8	9.7	10.3	9.9	10.0	11.4	10.2	10.8	4.7	5.3	5.0
7.5	9.6	8.6	8.0	9.6	8.8	9.5	9.0	9.2	9.6	8.4	8.9	4.4	4.8	4.6
.5	.2	.3	.6	1.2	.9	.8	.9	.8	1.8	1.8	1.9	.3	.5	.4
3.215	.693	1.923	2.635	.545	1.540	.909	.192	.525	.165	.026	.095	.379	.253	.318
2.849	.575	1.674	2.317	.430	1.329	.933	.165	.524	.210	.037	.114	.336	.216	.274
.366	.118	.249	.318	.115	.211	...	.027	.001	...	...	...	.043	.037	.044
...	...	...	...	...	...	.024	...	...	.045	.011	.019	...	...	...
28.6	6.7	17.7	23.5	4.8	13.7	8.1	1.9	5.0	1.4	.3	.9	14.	3.4	8.9
27.5	5.7	16.3	22.5	4.3	13.1	9.0	1.8	5.4	2.1	.5	1.3	14.3	3.1	8.6
1.1	1.0	1.4	1.0	.5	.6	...	.1	...	...	...	...	.4	.3	.3
...	...	...	...	...	...	.9	...	.4	.7	.2	.4	...	...	...

From this table it will be observed that as regards all forms of insanity, exclusive of general paralysis, the total increase of the average annual admissions is 0·4 per 10,000 of population, that up to the age of 44 the increase is generally under that proportion, and that the age-periods beyond 44 are marked by a much greater proportionate increase, one, too, which steadily increases with advancing years. With regard to general paralysis the reverse holds, for in the extremes of the age-periods there is an actual diminution, and it is in what may be regarded as the earlier general-paralysis period that the increase is most pronounced.* In other words, the race shows a lessening tendency to insanity in the earlier life-periods, but as regards general paralysis the increasing liability shows itself during the earlier years of the general-paralysis age.†

These facts are more clearly brought out by combining the figures for the several age periods. Thus, while the increase for all ages of the average annual admissions of all forms of insanity, excluding general paralysis, of the quinquenniad 1888-92 over 1883-87 is 0·4 per 10,000 of population, the increase for the age-period 15 to 34 is 0·3, from 35 to 44 0·3, from 45 to 54 0·9, and from 55 upwards 2·1; whereas the corresponding figures for general paralysis are respectively 0·018, 0·249, 0·211, and —2·013, the increase for all ages being 0·044.

The accompanying chart shows graphically the changes as regards general paralysis and other forms of mental disorder that have taken place in the five years 1888-92 as compared with the five years 1883-87, that is to say, the increase (per 10,000 of population) of the average annual admissions of general paralysis (interrupted line) and of other forms of insanity (continuous line) of the five years 1888-92 over the five years 1883-87, arranged in five age-groups. The horizontal lines represent the increase for all ages.

* Mickle, *General Paralysis of the Insane*, second edition, p. 250, gives 33 as the average age at onset of the soldiers under his care.

Arnaud (*Annales Medico-Psychologiques*, July, 1888, p. 86) observes that the mean age of general paralysis is lowered, and that the lowering is related to the greater frequency of the disease.

† Mickle (*op. cit.*) says, "Reading the older literature of the subject one is led to think that formerly general paralysis occurred somewhat later in life, on the average, than is nowadays the case."

Krafft-Ebing (*op. cit.*) gives statistics which point in the same direction.

Calmeil (*De la Paralyse considérée chez les Aliénés*, 1826, p. 371) gives the following figures for 45 general paralytics:—Age at onset: Up to 32, 4·4 per cent.; 32 to 40, 31·1 per cent.; 40 to 50, 44·4 per cent.; 50 to 60, 20·0 per cent.

CHART I.

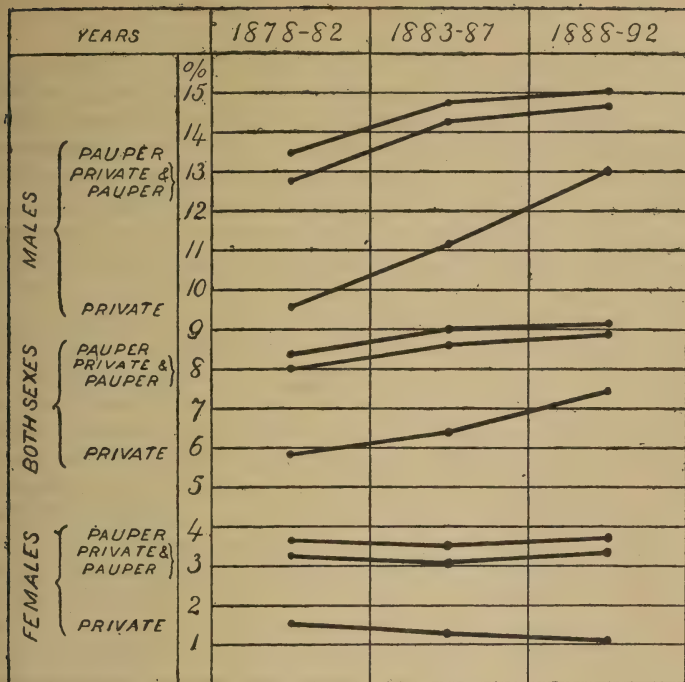
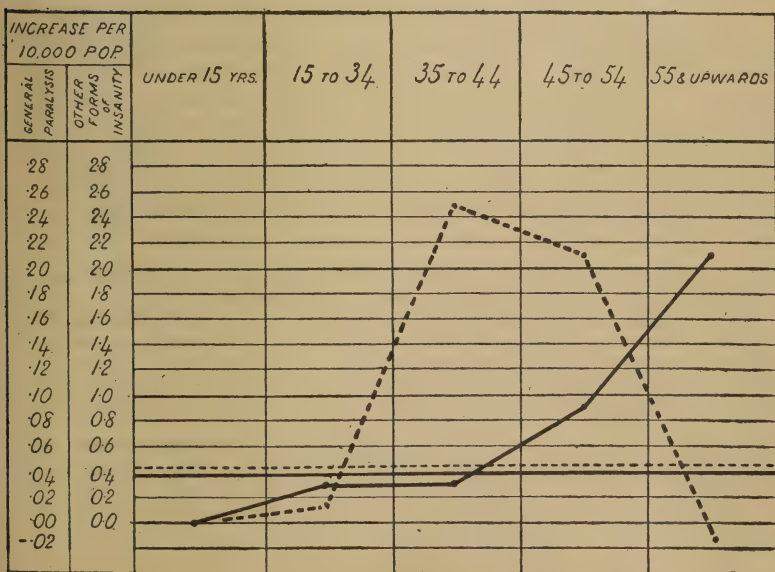


CHART II.



Marriage Relation.

TABLE showing the ratio (per 10,000) of the yearly average number (1) of patients exclusive of general paralytics, (2) of general paralytics admitted into asylums, etc., in England and Wales during the five years 1888 to 1892 inclusive to the census population of 1891, and during the five years 1878 to 1882 inclusive to the census population of 1881, arranged according to the condition as to marriage.

				Single.			Married.			Widowed.		
				M.	F.	T.	M.	F.	T.	M.	F.	T.
Admissions exclusive of General Paralytics	1888-92	}	1878-82	3·7	3·8	3·7	5·7	6·8	6·2	12·3	10·9	11·3
				3·5	3·5	3·5	5·6	6·4	6·0	10·6	9·5	9·8
Increase				·2	·3	·2	·1	·4	·2	1·7	1·4	1·5
General Paralytics, 1888-92 ...				·276	·056	·166	1·686	·038	1·028	1·526	·356	·709
,, ,, 1878-82 ...				·216	·046	·132	1·382	·033	·854	1·265	·330	·614
Increase				·060	·010	·034	·304	·005	·174	·261	·026	·095

Contrasting general paralysis with other forms of mental disorder, the order of increase (per 10,000) of the average annual admissions of the five years 1888-92 over the five years 1878-82 in relation to the marriage state, is as follows:—

Admissions, excluding General Paralytics.

Married Men	...	0·1
Single Men	...	0·2
Single Women	...	0·3
Married Women	...	0·4
Widows	...	1·4
Widowers	...	1·7

General Paralytics.

Married Women	...	0·005
Single Women	...	0·010
Widows	...	0·026
Single Men	...	0·060
Widowers	...	0·261
Married Men	...	0·304

The most striking feature of the foregoing figures is the position occupied by married men, for while the increase of the admissions (other than general paralytics) is least of all pronounced in their case, they most of all are responsible for the increase of general paralysis; in relation to these two groups of mental disorder they occupy the extremes. The extreme position occupied by married women and men in the increase of general paralysis is another very noteworthy point. The increase among single women is twice,

and among widows five times what it is among married women; while as regards men the increase among the widowed is over four, and among the married five times what it is in the single.

Geographical Distribution.

The geographical distribution of general paralysis is a subject of much interest as indicating some of its causes and the conditions giving rise to it. The available data, however, are for various reasons by no means complete; nevertheless those that are available afford indications of the highest value. It is only from the Annual Reports of County and Borough Asylums that the requisite information is to be obtained, and in consequence it is only the proportion of general paralysis among pauper patients that can be dealt with.

The following table shows the increase or diminution in the five years 1888-92 as compared with 1878-82 in the proportion of general paralytics per cent. of admissions in the case of 35 counties and 9 towns.

England and Wales, increase 0·7

COUNTIES.

Increase.				Decrease.			
Northumberland (including Newcastle) ...	...	5·58		Bedford, Hertford, Huntingdon <i>a</i> ...	...	0·26	
Glamorgan ...	...	5·10		Carmarthen, Cardigan, Pembroke ...	...	0·28	
Lincoln ...	...	2·83		Lancashire ...	...	0·31	
Warwick <i>a</i> (including Birmingham) ...	...	2·74		Sussex ...	...	0·45	
Derby <i>a</i> (including Derby Borough) ...	...	2·32		Oxford ...	...	0·45	
Cambridge ...	...	2·02		Yorkshire ...	...	0·57	
Monmouth, Brecon, Radnor ...	...	0·96		Wiltshire ...	...	0·65	
Hereford ...	...	0·71		Salop, Montgomery ...	...	0·75	
Gloucester... ..	...	0·40		Cumberland, Westmoreland ...	...	1·15	
Northampton ...	...	0·03		Stafford ...	...	1·35	
				Cheshire ...	...	1·65	
				Dorset <i>a</i>... ..	...	1·72	
				Hampshire ...	...	1·94	
				Worcester ...	...	1·99	
				Somerset <i>a</i> ...	...	2·88	
				Warwick (excluding Birmingham) ...	...	2·58	
				Nottingham (excluding Nottingham Borough) ...	...	3·89	
				Devon ... ..	...	4·91	

TOWNS.			
Increase.		Decrease.	
Newcastle ...	... 10·72	Leicester ...	... 1·03
Cardiff ...	... 6·91	Hull ...	... 1·00
London (City of) <i>a</i>	... 6·71		
Liverpool (Rainhill Asylum)	... 5·29		
Nottingham <i>a</i>	... 5·28		
Birmingham <i>a</i>	... 4·90		
Ipswich <i>a</i>	... 3·25		

a In these cases the periods contrasted are the five years 1883-87 and 1888-92.

What strikes one most forcibly on looking over this table is the position occupied by the large towns as compared with the rural counties. With but few exceptions the latter are characterised by an actual diminution in the proportion of general paralysis to admissions, while in the former there is an increase, which, relatively speaking, is enormous.

While the total increase for pauper patients in the percentage proportion of general paralysis to admissions for the whole of England and Wales between 1878-82 and 1888-92 is 0·7, Newcastle heads the list with an increase amounting to 10·72, and Devon comes at the other extreme with a decrease of 4·91. This increase appears more striking still when the sexes are taken separately, for in the case of males it amounts in Newcastle to no less than 15·28, and in Cardiff, where the increase for both sexes is 6·91, that for males is 13·61, and in Birmingham, where the total is 4·90, that for males is 7·46.

The increase in general paralysis is then associated in the closest fashion with life in large urban centres.

More than that. Of these large centres, the two which stand out most prominently, Newcastle and Cardiff, while representing the sea-port towns, have the further similarity that they are the chief centres of coal exportation in the kingdom.

Birmingham, again, when contrasted with the other parts of Warwick County, affords a striking illustration of the influence of urban life, for while in the county general paralysis is actually diminishing, it is quite otherwise in the city. Of the counties, it is noteworthy that the two which offer the greatest increase are those which are representative of the coal-mining counties, where wages generally rule higher than in any other part of the country. The condition of affairs in Lincoln is most likely to be accounted for by the presence within its borders of the port of Grimsby.

The fact that in Glamorgan in the intercensal period 1881-91 the population increased 33·70 per cent., while its mentally affected only increased 26·73, taken in conjunction with the further fact that the admissions of general paralytics increased 142·2 per cent. in the five years 1888-92 as compared with 1878-82, points to the conclusion that general paralysis, as regards its causation, stands on a footing quite different from other forms of insanity; and the fact that the counties which in general have a low rate of pauperism and of pauper lunacy are those which show the most pronounced increase of general paralysis, points in the same direction.

Furthermore it is surely, in relation to this subject, something more than a mere coincidence that with regard to the offence of drunkenness it is the sea-port towns which head the list and that next after them come the mining counties, the Metropolis and manufacturing towns, and that the lowest by a long way are the agricultural counties.*

These facts, as well as the data afforded by the table giving the causes of general paralysis, all go to form additional links in the chain of evidence of the close association of excesses and general paralysis, and of the debasing of the moral and physical currency which present-day urban life involves.

Assigned Causes of General Paralysis.

There now remain for consideration the tables given in the Reports of the Commissioners of Lunacy dealing with the "assigned causes of insanity" and the possible bearing they have in relation to the subject of this paper. In the table on next page the causes are stated for (1) all forms of mental diseases exclusive of general paralysis; and (2) general paralysis for the two quinquennia 1878-82 and 1888-92, and these two periods are contrasted, the difference being indicated by a plus or minus sign.†

A general survey of this table shows that certain factors have undergone no material alteration, while with regard to others, changes, some slight and some not so, either in the direction of increase or diminution, have occurred. Taking

* The proportion of the offence of drunkenness per 10,000 population in 1893 was:—England and Wales, 582·46; Seaports, 1,337·72; Mining Counties, 963·15; Metropolis, 600·64; Manufacturing Towns, 457·90; Agricultural Counties 167·79.—*Criminal Statistics*, 1893, p. 91.

† Inasmuch as in the etiological tables dealing with general paralysis no distinction is made between private and pauper cases, or between exciting and predisposing causes, it is necessary for purposes of comparison to take both classes of cases combined and the total causes.

TABLE showing by a Yearly Average the Assigned Causes of Insanity. (2) in the cases of General Paralytics admitted into Asylums in England and Wales during the five years 1878-1882 and during the five years 1888-1892, and the difference between these two periods.

	Proportion (per cent.) to the yearly average number admitted.												Difference between 1878-1882 and 1888-1892.			
	All patients exclusive of General Paralytics.						General Paralytics.						All patients exclusive of General Paralytics.			
	1878-1882.			1888-1892.			1878-1882.			1888-1892.						
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	T.
	4.2	9.8	7.2	4.1	8.9	6.7	3.4	9.3	4.7	4.5	9.7	5.4	1.1	4.4	7	7
CAUSES OF INSANITY.																
MORAL.																
1 Domestic trouble (including loss of relatives and friends) ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
2 Adverse circumstances (including business anxieties & pecuniary difficulties) ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
3 Mental anxiety and "worry" and overwork ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
4 Religious excitement ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
5 Love affairs (including seduction) ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
6 Fright and nervous shock... ..	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
PHYSICAL.																
7 Intemperance (in drink) ...	19.6	6.9	12.8	19.6	7.7	13.1	24.3	14.5	20.3	26.1	20.1	24.9	0.0	4.8	4.3	4.6
8 Venereal disease (sexual) ...	8.5	5.6	7.2	7.7	5.5	6.6	2.9	3.2	3.0	3.9	5.4	4.2	1.1	0.0	0.0	1.2
9 Self-abuse (sexual) ...	2.4	2.2	1.2	2.5	3.3	1.3	1.4	1.5	1.4	3.9	1.4	3.4	2.1	2.5	1.1	2.0
10 Over-exertion ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
11 Sunstroke ...	2.4	7.6	1.2	1.8	4.4	4.4	1.2	2.2	1.0	1.0	...	...	...	...	...	...
12 Accident or injury ...	4.9	1.1	2.8	4.6	1.0	2.6	7.3	2.2	2.5	1.7	...	...	...	...	...	...
13 Pregnancy ...	...	6.6	6.6	...	6.5	6.5	...	4.6	4.6	...	1.4	1.4	...	...	...	...
14 Parturition and the puerperal state ...	...	2.0	2.0	...	1.8	1.8	...	1.7	1.7	...	...	...	...	...	...	...
15 Lactation ...	...	2.7	2.7	...	1.4	1.4	...	1.2	1.2	...	...	...	...	...	...	...
16 Uterine and ovarian disorders ...	...	5.4	3.5	...	4.0	4.0	...	3.4	3.4	...	...	...	...	...	...	...
17 Puberty... ..	...	3.5	7.8	...	9.9	7.8	...	2.4	2.4	...	...	...	...	...	...	...
18 Change of life... ..	1.0	2.1	1.8	1.4	1.5	1.4	...	3.2	1.8	1.0	2.2	1.3	...	...	...	...
19 Revers ...	...	4.4	4.2	6.2	6.1	6.2	...	1.4	1.7	...	...	...	...	...	...	...
20 Privation and starvation ...	...	10.4	10.3	13.3	12.0	12.6	10.6	12.9	1.8	11.5	12.5	11.7	...	...	...	...
21 Old age... ..	18.9	17.0	15.5	18.2	2.6	19.9	4.7	7.5	5.3	5.2	7.2	5.6	...	...	...	...
22 Other bodily diseases or disorders ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
23 Previous attacks ...	18.7	20.8	19.8	21.5	25.2	22.8	14.2	16.7	13.9	15.4	18.6	16.0	...	...	...	...
24 Hereditary influences ...	6.2	3.6	4.8	7.2	4.4	5.7	...	1.6	2.2	...	...	...	...	...	...	...
25 Congenital defect ...	3.3	1.1	2.1	1.4	1.0	1.1	...	1.3	1.0	...	...	...	...	...	...	...
26 Other ascertained causes ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
27 Unknown ...	21.3	22.1	21.7	17.5	17.1	17.3	29.4	32.9	30.1	27.6	31.2	28.3	...	...	...	...

the "moral" causes together it will be observed that while these apparently diminish as factors in the production of insanity (exclusive of general paralysis), in general paralysis itself there is a not inconsiderable increase amounting to 1.4 per cent. It is unnecessary to treat each of the items of this table in detail; it will suffice to indicate the outstanding features. Dealing thus with the figures given, the following points seem to call for special mention. Foremost of all comes intemperance in drink. While the increase of this as an etiological factor in insanity amounts to only 0.3 per cent., in the case of general paralysis it amounts to no less than 4.6. The unfavourable position occupied by women in this respect will also be noticed. When the causes numbered 7, 8, 9 (alcoholic and sexual excess and venereal disease), which are in practice so often found together, are combined the result is more striking still.

Thus while the increase for insanity amounts to, males 0.4, females 0.9, total 0.4, in general paralysis the corresponding figures are 5.4, 7.6, 7.8. Surely here we have a light which is by no means uncertain thrown upon the causation of the increase of general paralysis.

Another interesting feature of this table is that which relates to the reproductive life in the female sex and which is comprised in causes numbered 14 to 19. Here there is as regards both forms of mental disorder an actual diminution, but while in that exclusive of general paralysis it amounts to only 0.8, in the latter it amounts to no less than 5.0. The significance of this fact is by no means a slight one.

The marked increase of "old age" in relation to the one form of insanity, and its marked contrast with the diminution in the case of general paralysis, fully bears out the remarks already made when considering the subject from the age-relation point of view.

"Previous attacks" and "hereditary influences" appear to be increasing factors in the causation alike of general paralysis and of other forms of mental disorder, though to a much less extent in the former than in the latter.

What part influenza, whose prevalence has been such a marked feature of the last quinquenniad, has played in the etiology of insanity, it is impossible from the data given to say. If it were included under the heading "fevers" it would seem to be responsible to some extent for an increase of general paralysis, but not of other forms of insanity; while, if it were included in "other bodily diseases and disorders," the reverse would hold.

The further question arises, whether it is possible from the tables of causes to arrive at any explanation of the previously remarked diminution in the ratio of general paralysis in private female patients. The evidence on this point is, for reasons already stated, only of an indirect kind, and is to be found in the tables which refer to mental disorders *inclusive* of general paralysis and in which the social condition is distinguished. According to these tables there is in the case of both private and pauper females a diminution in the second as compared with the first quinquennial in the proportion of the assigned causes termed "moral" which is greater in the case of the latter (0·8 and 1·0 per cent.) As regards those causes which relate to the reproductive life, while there is an increase of 0·1 per cent. in the case of private females, in the case of pauper patients there is a diminution of 1·0 per cent. These then afford no explanation of the decrease of general paralysis among private female patients, but quite contrariwise. It is different, however, with alcoholic intemperance. Here as regards private patients there is a diminution of 0·5 per cent., but in the case of pauper patients an increase amounting to 1·3 per cent. It may therefore be reasonably concluded that herein is to be found the explanation of the diminishing ratio of general paralysis among females of the private class.

The bald statement that the average annual number of general paralytics per cent. of the total admissions, which in the five years ending 1882 was 8·0, had in the five years ending 1892 risen to 8·9, may seem but a trifling matter. This increase of 0·9 is, however, by no means a slight one, for it represents a percentage increase in the annual admissions of 34·6, as compared with only 19·3 for other forms of insanity, and its significance too is great.

There is, so far as one can judge from statistics, no increasing liability to insanity on the part of the English race, but one is irresistibly compelled to conclude that in these latter years of this nineteenth century a change is taking place in the type of insanity, a change which surely indicates a reversion to a lower and more hopeless form of brain disease, a diminishing vitality, a lessening power of resistance,* and an increasing tendency to premature and rapid racial decay.

* Further and very powerful evidence of the diminishing power of resistance of the race is afforded by the disproportionate increase during the past twenty

A study of the age-incidence of the disease only serves to further deepen the significance of the fact. For not only is there an absolute total increase of this fatal affection, but it is chiefly in the earlier years in which it occurs that the increase is found to take place. In other words the tendency to race decay becomes not only more marked, but it becomes at the same time increasingly manifested at an earlier stage. This, as Mickle says when dealing with this aspect of the subject, "would speak ill for the vitality of the peoples of the West of Europe, as far at least as the disease may be deemed analogous to a prodigal wasting of vital power and premature senility, the earlier attainment of old age in the individual members of a race being the forerunner and prophet of its imminent decay."

The Source of the Increase.

As has already been stated, there are two outstanding facts referring to this point, and which are in a measure related. First, the increase is 19 times more among males than females. Further, the increase in males is twice as great in that section of society which furnishes private patients (upper and upper-middle classes) as that which occurs in the population from which pauper patients are derived (lower-middle and lower classes).

The unique position occupied by women of the upper and upper-middle classes already referred to is the only redeeming feature in this otherwise sombre picture. Whether the prevailing movement which has for its object the removal of existing inequalities between the sexes, and the increasing extent to which women are engaging in spheres of activity formerly restricted to men, will ultimately affect this position, time alone will show.

In the second place, the factors which have contributed most to this increase are these three—intemperance in drink,*

years of suicide, which to the extent of 98 per cent. is adjudged to be the outcome of insanity.—*Criminal Statistics*, 1893.

* The average annual proportion of persons per 10,000 of population tried for the offence of drunkenness in England and Wales during the four quinquennials ending 1893 was 812, 698, 636, 615. Here apparently is opportunity for congratulation. But are we justified in concluding that as a race we are becoming more "temperate?" Or is it that we are only a less drunken race? Custom has altered since the Pickwickian times, and to get drunk is now decidedly "indecent;" but are we in reality more temperate? Whether there is temperance or its opposite depends upon results. Drunkenness obviously implies excess; increasing general paralysis implies the same thing, not so obviously, but still none the less really. The significance of the replacement of drunkenness by general paralysis lies in the fact that it indicates a greatly increased tendency to race decay.

sexual excess, and its consequences. A study of these, and of those which are associated with the reproductive life in women, leads one to the conclusion that this ominous feature of the life of the nation is not related to the altruistic, other-regarding instinct, but finds its explanation in quite other causes. Selfish indulgence, lustful gratification, insatiable animalism, "general sensuality and fastness," these are to a very large extent the "grand parent-manufactory of the evil." "General paralysis," as has not inaptly been said, "is the apotheosis of selfishness." The opening chapter is moral decadence; the closing acutely rapid physical and intellectual degeneration and inevitable premature extinction.

There is very little, if anything, to show that the "struggle for existence," the "stress of circumstances" is responsible for the condition of affairs here indicated; rather is it quite the reverse. Exception must be made in the case of that class which furnishes no small proportion of general paralytics, and which is represented by the unfortunate being who "submits herself as the passive instrument of lust and appears in every age as the perpetual symbol of the degradation of man," and who in the great proportion of instances is impelled to the course of life by the most extreme poverty.

The Remedy.

The increase of this peculiarly fatal disease is, as has already been shown, to be traced chiefly to causes which are to a very large extent controllable, and the only direction in which a remedy is to be sought is in that of prevention. For general paralysis *in esse* remedy there is none (in the present state of our knowledge); death is inevitable, with mayhap a few years of respite such as it is.

The inequitable distribution of wealth, leisure, and knowledge is held by not a few to be the source and origin of the main part of the existent miseries of life, but what avails it if wealth and leisure come without the more essential knowledge? In spite of our School Boards and Christian educations, our "statistics, unshackled presses and torches of knowledge," there is still much ignorance abroad, even, and perhaps most so, among those classes commonly designated the "cultured," a deplorable, and often wilful, lack of knowledge in the real and true sense of the term, knowledge, that is, of the inexorable laws of life "in departing

from which lies and forever must lie, sorrow and defeat for each and all of the posterity of Adam in every time and every place."

Summary.

I.—There is no evidence of increasing liability to insanity on the part of the English race.

II.—There is evidence of an increasing tendency to general paralysis.

III.—This is most pronounced among males, in whom the increase is nineteen times what it is in women.

IV.—Among males the increase in private patients is more than twice that in pauper patients; in the former it is steadily progressive, in the latter it is a diminishing increase. Among females the increase in paupers is slight. In private female patients there is a steadily maintained diminution.

V.—The age at which the increase of general paralysis attains its maximum is the decade 35 to 44; in other forms of insanity the increase occurs at ages over 45 and is greatest at ages over 55.

VI.—The increase is greatest among married men, being five times that which occurs in unmarried men, and sixty times that in married women.

VII.—The greatest increase is found in large urban centres, most so in sea-ports and in particular coal-exporting towns; the next greatest in coal-mining counties and manufacturing towns, while in agricultural counties there is a decrease. A close parallel, as regards geographical distribution, is to be traced between the increase of general paralysis and the occurrence of the offence of drunkenness.

VIII.—The etiological factors most responsible for the increase are alcoholic intemperance, sexual excess, and venereal disease. The causes connected with the reproductive life of women are diminishing as factors in the production of general paralysis. The increase finds its origin in causes related to the self-regarding, not the altruistic, instinct.

IX.—The increasing prevalence of general paralysis indicates a change in the type of insanity, a reversion to a lower form of brain disease, increasing moral and physical decadence, lessening power of resistance and diminishing vitality, and increasing tendency to premature and rapid racial decay.

X.—The affection being absolutely fatal, and the causes being to a very large extent controllable, the only direction in which the remedy is to be sought is in that of prevention.

*The Hospital Treatment of the Insane in Asylums.** By J. MACPHERSON, M.D., F.R.C.P.E., Medical Superintendent, Stirling District Asylum.

It is scarcely 20 years since those interested in asylum administration in Scotland began to realise that the interests of the sick and infirm were not so adequately provided for in asylum construction as the requirements of such patients demanded. The desire to improve the efficiency of asylums by providing ampler accommodation for the treatment of that class of patients gradually extended itself so as to include within its scope the treatment of the acutely insane in combination with the sick and infirm, that is, all the inmates of asylums who especially require the services of the physician and the nurse. This idea again expanded itself until a rearrangement of the whole asylum population into two main portions was proposed. The smaller portion was to consist of the newly-admitted cases, of cases requiring special medical attention for any reason, and of the sick and infirm cases. The larger portion was to consist of the quieter chronic and industrious cases for whom the same active medical and nursing supervision was unnecessary. This, which may be called the hospital movement in the Scottish Asylums, has now attained practical expression, and has with considerable variety certainly, yet with conspicuous uniformity in its main principles, been adopted in upwards of 50 per cent. of the public asylums of the country.

It would be impossible for a movement such as this to advance to its present state of achievement without the aid of a leader, or, at any rate, of an example, and without the support of somebody of opinion with sufficient influence to make itself felt and heard. Between the years 1877 and 1882 extensive improvements and alterations were made by Dr. Clouston upon the West House at Morningside. Among the most important and significantly far-reaching of all these changes was the conversion into hospitals of two one-storeyed blocks of buildings, one on each side, at the extremities of the male and female divisions of the asylum. These blocks were originally used as wards for noisy and troublesome patients, and were situated at considerable distances from the main buildings, so that the noise of the refractory patients, more especially at night, might not disturb the quieter patients. Out of these blocks, unsuited

* Read at the Annual Meeting of the British Medical Association, Carlisle, 1896.

by design, conformation, and traditions for the purposes of hospitals, Dr. Clouston constructed what were for some years the best if not the only separate Asylum Hospitals in Scotland. No person could walk through them without being struck by the comfort afforded to the patients by means of the decorations, the large staff of nurses, the comfortable beds and the large number of bright well-heated, well-ventilated single rooms for the acute, feeble, infirm and aged cases. Under this system the nursing, especially of the female aged and infirm cases at Morningside, reached a degree of perfection that it would be impossible greatly to improve upon.

This formed the germ of the movement. Its influence rapidly spread until the idea had rooted itself as a possibility in the minds of asylum administrators throughout the country. The idea was fostered and encouraged by the Board of Commissioners, who concentrated for a time their recommendations in the matter of asylum improvement and extension in the direction of the hospital system. The model plans of the Board of Commissioners prepared by Mr. Sydney Mitchell in 1880 in view of the immediately impending great asylum extension in Scotland, were designed to illustrate an asylum providing accommodation for 1,000 patients, and they gave the first complete form to the idea of the administration of the hospital separately from the rest of the asylum.

In these plans an asylum was divided into two separate sections, the smaller of which—the hospital—was constructed for the accommodation of one-third of the entire population. The hospital was furnished with a small administrative block, a kitchen and a dining hall, and was for all purposes completely isolated and self-contained. Without taking into consideration the two primary divisions into male and female sides, the hospital was divided into three sections. 1. A section containing all the newly-admitted cases and all cases requiring special supervision, either on account of suicidal tendencies or for any other similar reason. 2. A sick-room section or general hospital wards for the treatment of medical and surgical cases, or for all cases requiring ordinary hospital treatment on account of either bodily or mental illness. 3. A section devoted to patients requiring special nursing on account of general feebleness, wet or dirty habits, or other peculiarities which demand treatment of a special kind.

These plans were being constantly submitted by the

Central Board to the various authorities who were engaged in the consideration of the best methods of asylum construction and extension, and at the same time the claims for a more specialised, more separate and more emphatic treatment of the acutely insane and the sick and infirm insane were persistently and powerfully urged.

The influence of the General Board in fostering the idea and keeping it before the public cannot be over-estimated. There is, I am sure, no claim for originality, either national or individual, put forward by the most ardent advocates of the system in Scotland. As to precedence in the detached hospital principle, we do not fail to recognise what has been done in foreign asylums and Lunatic Colonies. Where asylums like Alt Scherbitz, Emmendingen, or Kankakee are built upon the separate pavilion system, it is necessary that they should possess central pavilions into which all new cases may be admitted for purposes of observation and medical examination, and into which all recurrent cases of mental disturbance are returned for treatment during the attack.

Further, it is evident that these institutions must have in their central department accommodation for the medical nursing and treatment of the sick and infirm. To a much greater extent does the idea of the separate hospital appear in the large continental lunatic colonies of Gheel, Lierneux, and Dun-sur-Auron. The cottages of the peasantry in such districts are wholly unsuited for any but the placid and manageable insane, which necessitates the admission of all cases to the hospital in the first place, and the immediate return thereto of all excited and turbulent cases. It is obvious that in these colonies where the patients consist so largely of chronic cases the hospitals must be small. Of the 1,900 patients in the Gheel colony not more than 70 were in hospital, while of the 400 and 200 in Lierneux and Dun-sur-Auron respectively, there were only six in hospital in the former and none in the latter when I saw these colonies last year. It is right to explain that acute cases are not excluded from Gheel and Lierneux, while only chronic suitable cases from the asylums of the department of the Seine are sent to Dun-sur-Auron. The principle of the Scottish Asylum Hospital carried to its highest development is the same as in the Colony Asylums and Lunatic Colonies I have mentioned, viz., a central curative medical and nursing department separate from the home for the care of the quieter chronic and industrious class of patients.

There are thirteen asylums at the present time in Scotland which have adopted in various ways and according to the views of their administrators the hospital system. The leading idea—separate and special accommodation for the mentally and physically sick—is in every case the same. The methods vary in almost every instance, but a rough classification may be made as follows: In six asylums the hospital is a separate, detached, and practically independent building; in seven it consists of special accommodation added respectively to the male and female sections of the asylum.

The latter system, which is not peculiar to Scotland, may be described as a compromise, being on the one hand a concession to the older and traditional method of asylum construction, and on the other an acknowledgment of the principle of the newer idea. The first of these was opened in 1889 at Murray's Royal Asylum, Perth, and the most recent examples of this mode of hospital construction are to be seen in the Barony Asylum at Lenzie, and the new Lanarkshire Asylum at Hartwood. In neither instance is the separate hospital system carried out in its entirety. At Hartwood only those cases among the admissions which seem to require medical attention on account of physical disease or weakness are sent to the hospital. Excited cases, recurrent cases, and acute mental affections are not treated in the hospital. In fact, it is on the lines of Morningside. At Lenzie new wards and dormitories for recent and acute cases were added to the old infirmary section on each side, thereby converting the old sick and infirm wards into modern hospitals.

The system of attached hospital wards is being most perfectly developed at the Inverness Asylum and the Perth District Asylum at Murthly. In each of these asylums operations are in progress for converting the wings of the main buildings into special hospitals, each wing (male and female) being divided into four sections—for receiving all recent acute cases and all cases requiring general hospital treatment and special supervision, while at Murthly Convalescents are provided for in separate houses.

The credit of building the first detached hospital in Scotland is due to Dr. Howden, Montrose. His views are not quite in accordance with those I have just indicated, especially with reference to the admission of recent cases, the majority of whom he considers are better treated in the admission wards forming part of the main buildings of the asylum.

The Montrose Hospital, which was opened in 1889, and which was admirably and beautifully constructed, formed the model, or, at any rate, gave the suggestion which led to the building of the other detached asylum hospitals that are either in use or approaching completion in Scotland at the present time. The asylum hospitals at Aberdeen, Fife, Glasgow, Govan, and Stirling provide accommodation for all new cases without exception; for cases of acute recurrent insanity occurring in the asylum; for cases requiring ordinary hospital treatment, and for the feeble and infirm. These hospitals afford accommodation for between 25 and 35 per cent. of their asylum populations, and each is divided into from three to five sections for the treatment of an equal number of classes of the insane. The type of detached hospital will be found most fully developed and perfect when completed in the Glasgow and Govan Asylums. In these asylum hospitals the observation ward, which all recent cases enter in the first place, forms a special and admirable feature. These wards, which are small and provided with beds, are situated near to the front door, so that first impressions of a disagreeable kind are as far as possible evaded, and the patient passes gradually into the reality of asylum life.

In the attached hospitals which are in course of erection at the Inverness Asylum, Dr. Keay, I am glad to observe, has in prospect the construction of convalescent wards. I regard these as of great value, not only as adjuncts towards completing the satisfactory recovery of many cases and as observation wards, but also as being the only possible means of enabling us to prevent some patients from coming into contact with what from one point of view may be termed the seamy side of institution life as represented by the chronic wards of an asylum.

The hospital of the Stirling Asylum is unfortunately smaller than the requirements of our large admission rate demand. Consequently, curable cases have constantly to be transferred to the other parts of the asylum earlier than I should wish. Whenever the patient is sufficiently rational to appreciate the removal from the hospital to another section he invariably dislikes it, and I have heard patients congratulate themselves when being discharged recovered that they had not been sent to the "asylum."

Another section might be with great benefit added to modern asylum hospitals, viz., isolation wards for the treat-

ment of pulmonary phthisis. These cases require constant nursing and their presence among the ordinary sick is a source of active danger. In the famous Illenau Asylum there is a beautifully constructed one-storeyed pavilion with glass verandahs all round it for the sole use of such cases.*

In a paper of such limited length I cannot enter into the many details that distinguish one hospital from another, but enough has been said, I trust, to indicate the significance of the movement, its wide extension, and the manner of its application. I can foresee many objections from a conservative point of view that might be urged against this system by those who have either not had experience of its working, or who have never seriously considered it. For instance, I have heard a celebrated continental alienist remark that the term "hospital" applied to a section of an asylum in this sense was nothing short of blasphemy, the implication of course being that all parts of an asylum should be an hospital. No doubt such an aspiration is ideally perfect, and I for one heartily concur, while at the same time pointing out that all parts of an hospital are, or ought to be, different from one another, some possessing more of the hospital character than others. The various parts even of an asylum of the prevailing type must present contrasts of a striking kind if classification is at all carefully attended to. Again, there is probably no modern asylum in this country that does not possess a section for sick and infirm patients, and another for recent and acute cases. What then, it may be asked, is the difference? Some may argue as follows: "In the one case the sections are separate, in the other combined; but the treatment in the one is as efficient as in the other. You erect a large detached ward or pavilion in which you place groups of incompatible cases on a bad basis of classification; you are pleased to call it an hospital, and you claim superiority for it."

I admit that the distinction appears to be a comparatively slender one when thus stated, but the departure in the separate hospital direction is nevertheless more important and vital than a mere verbal comparison such as this can convey. I cannot conceive of any opponent of the system suspecting us of harbouring the idea that the mere fact of having a separate hospital attached to an asylum carries with it the right to claim any superior medical or nursing

* At Ville Juif, Paris, the phthisical patients live in the open-air, sleeping in a curtained verandah all the year round.—Ed.

skill on the part of the staff. Far from it. The contention is that the re-arrangement in the structure of the asylum, and in the classification of the patients, possesses certain marked advantages from a clinical and therapeutical point of view.

1. First and foremost among these advantages is the nursing of the patients. It is of primary importance to the working of the system that all the sections should be under the charge of one nurse. In this way only can all classes of the insane—acute, sick, and infirm—participate equally in the benefits of sound nursing. The true nursing spirit will always tend to generate itself most effectively in the sick and infirm section of an asylum, and most often the best nurses and attendants are found in those wards. In Asylum Hospitals the sick and infirm are placed as far as possible in the midst of the most favourable conditions for treatment, and the nursing spirit and training that necessarily comes from constant contact with the sick and bedridden is extended with the best results to the recent and acute cases. The inclusion of the acute and recent cases for combined treatment with those suffering from bodily illness, under one head and one nursing staff, is an emphatic acknowledgment of the fact that the mentally afflicted are entitled, as all asylum physicians hold, to an equal share of the tender attention that is universally accorded to patients suffering from bodily disease or infirmity. It is further a recognition of the similarity in origin and of the similar principles of treatment for mental and bodily diseases. This is not without its influence upon the general behaviour of the nurses. In its simplest forms that attention is manifested by a more accurate observation on the part of the nursing staff of the physical side of the phenomena of mental affections, and a greater facility in the use and command of many important agents in the treatment of the insane, such as couches, beds, extra food, baths, etc., that result from an association of sick and infirm wards with those for the reception of new cases. The result of this combination of patients for nursing purposes is, according to my short experience: (1), a fuller recognition by our nurses of a fact which it is vitally important for all concerned that they should learn, viz., that a madman is a sick man; (2), the awakening of a fresher and more interested sympathy towards cases of acute insanity; (3), a greater amount of individual treatment of the cases; (4), a more evident bond of friendship between

nurse and patient than formerly existed has sprung up in consequence of this system; and (5), a marked diminution in the discontent and dislike to asylum restraint which the majority of new cases manifest on first admission. (I have been often impressed by the aversion which many of the more rational patients exhibit to being transferred from the hospital to other parts of the asylum, as well as by the willingness of many chronic patients to be sent to the hospital for treatment.) The possibility which this system affords for the introduction of female nurses into the male wards is one of its chief advantages. I consider, therefore, that the facility the hospital system affords for the combined nursing of the various classes of patients already mentioned to be its outstanding merit.

2. The medical treatment and study of the insane is facilitated in a manner that is impossible under any other system. It is no longer necessary to separate cases of puerperal insanity from ordinary cases of acute mania by long distances which render synchronous observation impossible, or to send two cases of general paralysis each to different parts of the asylum. The order to place a chronic patient under stricter supervision implies, in addition to greater security, the conferring on the patient of many other important benefits. Recurrent attacks in chronic patients are treated in the same way as if they were recent. Their isolation is not only attended by relief to their quieter fellow-patients, but, combined with active treatment, tends to shorten the attack and to prevent the host of unpleasant incidents that usually accompany such attacks when left to expend themselves in ordinary asylum wards. The grouping of such cases is, therefore, most important, for it concentrates the energies of the medical staff and thereby facilitates case-taking, clinical observations, the carrying out of special medical directions, and the constant supervision of the physicians.

3. Another advantage which may be pointed out is that administration is much simplified under this arrangement. All those cases that in an asylum give rise to most anxiety for any reason are concentrated in a smaller area, and in this way the risk of accidents and of danger is diminished by one half, for the opportunities become correspondingly limited. Explosive units scattered over such huge populations as many modern asylums possess are necessarily uncertain, and may at any moment react in the most unforeseen manner.

When these units are collected together under the supervision of a numerically strong nursing staff, both the danger and the anxiety decrease *pari passu*; and when all such cases, whether they cause anxiety on account of insanity, physical illness, suicide, or homicide, come under uniform treatment of a palliative kind, we should expect to find a further diminution in the chances of the occurrence of those multitudinous mishaps that fortunately loom larger in apprehensive imagination than in fact, but which are not the less harassing on that account.

4. Administration, moreover, is further simplified by ridding the chronic insane of the disadvantages to them which association with noisy, acute, or special cases of any kind necessarily involves. Association in the same wards and dormitories, which is sufficiently objectionable, is effectually avoided; but there are many other disadvantages which also disappear. The tranquillity that ought to pervade the apartments forming the life-long home of two-thirds of our asylum inmates is no longer broken in upon. The ward and kitchen staffs of the main building are no longer distracted by special duties or special diets. The dining halls are quiet, orderly, and peaceful, and everything in the daily routine adapts itself to the special wants of the semi-industrial community for whose happiness such a system is essential.

5. The contiguity of the two sections, the constant transference of patients from one to the other, the presence of large numbers of incurable patients in the hospital, and the undivided control of one responsible head, prevents the formation of any unfavourable contrasts between chronic and curable cases. The idea of curability or incurability does not enter as a factor into this arrangement. The classification has other and more humane objects, chief among which are, as I have already indicated, the more emphatic and more effective treatment of the large class of the insane for whom active medical and nursing attention is necessary, and the provision for the quieter chronic and industrious insane of that amount of comfort and calm which their life-long residence in an asylum demands.

Such, briefly, is an outline of what I have called the Asylum Hospital movement in Scotland. It would be foolish to describe it as a perfect working system or as a final solution of the problem and difficulties of asylum administration. It is, however, one of the most important departures made

in Scottish lunacy administration during the last 40 years, and will, it is to be hoped, be judged in the future not by any results of treatment, statistical or otherwise, but according as it harmonises with those leading humanitarian and medical principles which have always actuated the greatest minds and the greatest movements in our specialty.

Note on Female Nursing in an Asylum Male Sick-room. By A. R. TURNBULL, M.B.Edin., Medical Superintendent, Fife and Kinross District Asylum.*

My object in this paper is to give a brief note of a trial which has recently been made in the Fife Asylum, in the way of introducing female nursing in the male sick-room. Nursing is peculiarly woman's province; and it has, I believe, often been felt that it would be a great advantage if female care could be more freely utilised in the management of male insane patients, or at least of those of them who are suffering from special bodily disease in addition to the mental symptoms. The main objections to the step have hitherto been: (1) that some of the habits and peculiarities of the male insane may make it unfit or undesirable to have them under female care; and (2) that in many asylums the structural arrangement makes it difficult or impossible to bring the male sick-room under systematic supervision by the female staff. Lately it was necessary to build a large addition to the Fife Asylum; and advantage was taken of this opportunity to get rid of the second objection mentioned. The new building is a hospital block, and is intended to receive recent admissions, cases requiring *special* observation on account of their mental state, and cases of bodily illness. Each side (male and female) is divided into three sections: 1st, sick-room proper (for cases of bodily illness); 2nd, special observation ward (intended for new cases, and cases needing continuous supervision on account of suicidal or other dangerous tendency); and 3rd, general observation ward. There are the usual dining-hall, kitchen, and administrative rooms in the centre of the building. The male and female sick-rooms are placed next to the administrative portion, one on each side; and as the doors here are unlocked during the day, with free communication by the corridor, the male sick-

* Read at the Annual Meeting of the Medico-Psychological Association, London, July, 1896.

room is easily reached from the female side, and is administered by the matron, the head nurse (who has charge of both sick-rooms), and two junior nurses. Each sick-room communicates with a special observation dormitory, beyond which again is the special observation day-room. This dormitory is empty during the day, but receives at night the cases which require continuous supervision on account of suicidal tendency, and which come to it direct from the special observation day-room. On the male side the door between the sick-room and the observation dormitory is kept locked during the day; and there is thus no direct communication between the sick-room and those parts of the male side which are under the charge of attendants, except by the general corridor. When the Medical Officer makes the evening visit, this door is unlocked, and the sick-room and observation dormitory are thrown into one and come under the charge of a male attendant, who is on duty during the whole night, while the nurses return to the female side of the building. This plan was followed because our numbers are too small to require separate attendance in the two rooms; and in this way the sick-room is under female care during the day, but is supervised at night by the male staff.*

When the building was being brought into use, I at first intended that a qualified nurse should have charge of both sick-rooms, but that on the male side she should be assisted by attendants, not by nurses. The matron and senior nurse, however, while willing and indeed anxious to try the work, said they would rather undertake it with the assistance of other nurses than in association with male attendants; and I willingly agreed to making the trial in this way, though I was not quite free from the old feeling that probably some amount of male assistance would be necessary in managing the patients. The result has been very successful. Various forms of bodily ailments, of the kind usually met with in asylum work, have been treated in the sick-room, such as general paralysis, epilepsy, other forms of organic brain disease, influenza, lung affections, senile breakdown, skin diseases, peri-typhlitic abscess, and minor surgical conditions (abscesses, ulcers, bedsores, etc.). These have occurred in patients who varied very much in their mental state, and showed conditions of congenital imbecility, dementia, simple and subacute mania, delusional mania, chronic mania, and

* A sketch plan of the building was exhibited, showing the arrangements described.

acute and chronic melancholia; and it has been found quite practicable to have them all under female care. Even on those points which occur to one at once as likely to lead to difficulty among insane patients on the score of decency or delicacy, there has been no serious trouble. In many cases the patients learn very quickly to assist themselves and to be correct in their habits; and when they are too demented for this, the difficulty can often be tided over by a little tact on the part of the nurses and assistance from some of the other patients in the room. When a patient is very helpless, the difficulty of managing him is of course not more serious than it would be in nursing the same kind of bodily illness in a sane patient outside an asylum. In passing I may mention that we have a female patient assisting regularly in doing the housemaid's work of the male sick-room.

I always desire that all cases confined to bed for bodily illness—but not necessarily those in bed for mental excitement only—should be in the sick-room, instead of being left in other wards; and generally it is quite practicable to accomplish this, even though the sick-room is during the day managed entirely by females. It is very exceptional that some feature in the mental state of the patient makes it impossible to place him in the sick-room, or necessary to remove him if he has been sent there. Indeed one or two patients who were very turbulent and troublesome under the old plan of male nursing have proved much more amenable to control, and more contented under the new arrangement; and another case who at first scouted the idea of being looked after by women became both pleased and very grateful for the nursing he received. The general impression given of greater attention to and greater deftness in the various details of nursing, and of the consequent enhanced comfort of the patients, is very gratifying. The presence of the nurses gives a different and better tone than what generally prevails in a ward with only male occupants; and in this way, as well as in the more efficient nursing, the plan is distinctly beneficial to the patients. It seems to me to have also a good effect on the staff, as they realise better that their work is one of true nursing; and the nurses often say that there is less difficulty in managing the male sick-room than in managing some of the female wards.

In connection with such sick-room work, it is, I think, very advantageous to have great facility for moving patients from ward to ward according as their mental or bodily condition

may require; and for this purpose the hospital block in the Fife Asylum is connected to the old building by a corridor on both the male and the female side. For example, we have a patient suffering from congenital imbecility with epilepsy, who, in connection with the fits, is subject to attacks of acute excitement with intense irritability and violence. During these attacks he is placed in a small ward in the old building reserved for the management of noisy and excited cases. In the confused and exhausted state following the excitement—a time when he is best in bed—he is in the sick-room, and can be suitably nursed; while in the quiet stage of his mental round he goes to one of the ordinary wards.

I wish to guard against giving the impression that I consider the step taken at the Fife Asylum as something entirely new. I have been informed that in the Worcester Asylum twenty years ago several of the male wards were partly supervised by females; and I know that in a number of asylums female nursing has for several years past been more or less in use in the male sick-room, though usually in combination with some assistance by attendants. The points on which I wish to lay stress are: (1), the advantage gained by having the male sick-room so placed that it can be suitably administered by the female staff; (2), the proof that it is possible to manage an asylum male sick-room successfully with female aid alone, just as is done in the male wards of an ordinary civil hospital; and (3), the great benefit, both to the patients and to the staff, of utilising female nursing as much as possible in the care of our sick male insane cases.

The Cairo Asylum.—Dr. Warnock on Hasheesh Insanity.

By. T. S. CLOUSTON, M.D., Edinburgh.

In the year 1879 Dr. Urquhart and Mr. W. S. Tuke each wrote an account in this Journal * of his visit to the asylum at Cairo, which was then, and is now, the only institution for the treatment of the insane in Egypt. Their impressions were most unfavourable. Dr. Urquhart says, "there is" in Cairo "no more melancholy and degrading fact than the common madhouse." "The Conolly of Egypt has still his work to do." "The whole place is so utterly beyond the ken of civilisation that it remains as hideous a blot on the earth's surface as is to be found in the Dark Continent."

* April number, 1879.

Mr. Tuke said:—"The place looked intensely squalid;" "with regard to the means employed in Egypt for the cure of insanity, I find that bleeding is the chief therapeutic remedy." No statistics could be obtained by either visitor. Since then the institution has been removed from its old site in a suburb of the city out to a palace and stable of the late Khedive Ismail at Abbasiyeh, about three miles north of Cairo. The weakness for palace building of his late Highness was one well-known feature of that sumptuous ruler's character. What to do with those gorgeous buildings was one of the difficulties of the English Government when it assumed the control of the country. One in which 200 of his wives and concubines had been magnificently housed is now turned into the zoological gardens. Where the fair Circassians lounged is the habitation of fierce beasts of prey. The marble walks laid out for the delicate feet of those ladies are now trodden by the gaping crowds of holiday Cairene visitors. Another palace has become a most sumptuous hotel. Another contains the priceless treasures of Egyptian antiquity at Gizeh. Several have been turned into soldiers' barracks, and many more are mouldering to decay. The insane of Egypt were not thought worthy of the best of those palaces. What was good enough for his Highness's horses was surely good enough for Egyptian lunatics. So to them was assigned the stable palace with its accessories. No doubt it was a great improvement on its predecessor, but under Egyptian management and control it was far from being an ideal hospital for the insane. Soon after Rogers Pasha was put at the head of the Sanitary Department, in which the treatment of the insane is merged, he saw that native management of the asylum was wanting in initiative, in honesty and in intelligence. So he got permission to appoint a British Medical Superintendent, and he has succeeded in investing him with large powers. Fortunately he secured the services of Dr. Warnock for the position. That gentleman's first Report, for 1895, now lies before us, and a most interesting document it is. We know from a visit we lately paid to the institution that the facts are true, and that the revolution from psychiatric darkness into light that has come about is very modestly understated. No man who has the welfare of the insane at heart but must rejoice that a great work is being thus carried out in behalf of the most helpless of mankind. Dr. Warnock's difficulties were at first enormous. He found dirt, disorder,

and dishonesty rampant, neglect of the patients the rule, and modern scientific treatment of mental disease conspicuous by its absence. The patients were severely drugged, badly fed, insufficiently exercised, and vigorously restrained by means of the camisole. In and about one bed—a fair specimen of the rest—he counted 3,000 bugs, lice, and fleas, and now he fines the attendant in charge a piastre for every bug that is seen! In the year 1894 the death-rate was 33 per cent.; in 1895 it fell to $16\frac{1}{2}$ per cent. on the average numbers resident, and in the last half of 1895 it fell one-third as compared with the first six months of that year. It must be kept in mind that the death-rate of the city of Cairo is about 40 per 1,000, or more than twice that of London. Organisation and order has been introduced everywhere. An almost entirely new and better staff has been engaged. When Dr. Warnock went there no female nurse could read the number on her ward door nor tell the time of day from the clock. Punctuality was unknown. There was no employment for either sex. Now we saw a very large number of men and women usefully at work. Noise by night and day has vastly diminished. Dr. Warnock says:—"Regularity and order are of slow growth, but in the end must prevail." Parasites and the tubercle bacillus and the diseases they cause, have afforded the subordinate medical staff their chief employment, but Dr. Warnock looks hopefully forward to the time when a thorough mental and bodily examination of each case, systematised case-taking and the use of scientific methods, will bring his hospital up to the level of the British standard. The dietary has been improved in quality and service. There were 526 patients admitted in 1895, while the average number resident was only 465. We believe no such proportion of new cases to resident population exists in any asylum in Europe. This is not one of the least of the difficulties of proper treatment and management in the Cairo Asylum. Few of us would like to face such a yearly influx into our institutions. There is far too little land attached to this asylum, and it is too close to a public road. The structure and arrangements of the building fall far short of our European modern standard. Yet Dr. Warnock works on hopefully and successfully. He has to be doctor, steward, architect, clerk of works, and general manager. And all this with a staff of semi-civilised Arabs, scarcely one of whom he can trust as we trust our kitchen-maids! Let

any man in Great Britain who is discontented with his asylum and his staff go to Cairo and spend a day with Dr. Warnock, and he will become profoundly thankful for his privileges. In his isolation from professional stimulus, with his stable-palace and its glaring structural defects, with his stolid Arab staff and his Arabian desert without a blade of grass as an outlook, he deserves our sympathy and admiration for what he has accomplished in his year of office, and for the pluck with which he faces his task. No one but an enthusiast could have done as much. All English officials in Egypt need to be young, healthy, hopeful, and tough. Their work takes a lot out of them.

Dr. Warnock has some interesting facts in regard to hasheesh and its mental effects. Of his 253 admissions in the *last* half of 1895, 40 were put down to the abuse of hasheesh, and 40 more to the combined effects of this drug and alcohol. Of 80 cases only five were women. In 41 per cent. of all his male patients hasheesh alone or combined with alcohol caused the disease, while in only seven per cent. of his female patients was this the case. After stating that the habit of smoking Indian hemp is widely prevalent in Egypt, he asks: "Is there a form of insanity produced by this habit so frequently occurring or of so peculiar a type that it can be demonstrated by asylum statistics? And is hasheesh a potent factor in the production of insanity in Egypt?" His conclusions are: "1. I have no doubt that in quite a considerable number of cases here hasheesh is the chief, if not the only, cause of the mental disease. 2. I doubt very much if hasheesh insanity can be at present diagnosed by its clinical characters alone. Many hasheesh cases recover almost immediately on their admission, an abstinence from the drug being in such cases followed by a cessation of the morbid symptoms." This sudden and rapid recovery is the most pathognomonic symptom. He classifies the usual types of hasheesh insanity as being:—

"*a. Hasheesh Intoxication.*—An elated, reckless state, in which optical hallucinations and delusions that devils possess the subject frequently exist. Sometimes the condition amounts to a delirium, which is usually milder, more manageable, and less aggressive than that of alcohol, and exhibits none of the ataxic phenomena of the latter. Recovery takes place in a day or two or less, and the patient usually recognises the cause of his excitement." In con-

nection with this "intoxication" Dr. Warnock asks if the subject of it is to be held responsible for crimes committed in this state or not?

"*b. Acute Mania.*—In this type terrifying hallucinations, fear of neighbours, outrageous conduct, continual restlessness and talking, sleeplessness, exhaustion, marked incoherence and complete absorption in insane ideas are the prominent symptoms. Such cases last some months, and do not always recover."

"*c. Weak-mindedness*—with acute outbreaks after each hasheesh excess. These cases are very numerous. While in residence such patients are quiet usually, and well-behaved, and only betray the impaired state of their brains by being over-talkative, easily pleased, lazy, anergic, excitable on small provocation, unconcerned about their future, and willing to stay in hospital all their lives. They show no interest in their relatives, and only ask for plenty of food and cigarettes. After being discharged such cases soon return in a condition of excitement—in fact in a mild form of type *b*. They then talk rapidly and rush about, pouring torrents of abuse on those near them; curse and rave on slight provocation; are sleepless, and for ever moving in an aimless way; are urgent to be released. They deny the use of hasheesh at one moment and boast of its wonderful effects the next. Besides these types there are numbers of cases of chronic mania, mania of persecution, and chronic dementia alleged to be produced by hasheesh, but I have no means of verifying these allegations." Dr. Warnock then quotes some of the conclusions of the "Indian Hemp Drug Commission" of 1893-94. "Its moderate use has no physical, mental, or moral ill-effects whatever." "Its excessive use injures the physical constitution, and may cause dysentery and bronchitis. It tends to weaken the mind, and may cause insanity sometimes. It induces mental depravity and poverty, but rarely crime. The injury caused by excessive use is confined almost exclusively to the consumer, and scarcely affects society." The Commission thought that careful inquiry reduced the proportion of real hemp drug cases. "Of 222 cases of insanity ascribed to hemp drugs in the Lunatic Asylum statements of 1892, only 98 are found on careful inquiry by the Commissioners to have any connection with them. The result is that of the whole number of cases admitted to lunatic asylums (in India) in that year only 7·3 per cent. can be ascribed to hemp drugs, and if

cases in which hemp drugs have been only one of several possible causes are omitted, the percentage falls to 4·5. . . . Hemp drugs cause insanity more rarely than has popularly been supposed, and the resultant insanity is usually of a temporary character and of shorter duration than that due to other causes." Such are the latest words in regard to hasheesh and its insanity.

Torquato Tasso and his Biographers. By WILLIAM W. IRELAND, M.D., Mavisbush, Polton.

(Continued from page 493.)

While at Belriguardo Tasso wrote a letter to the Cardinal, who directed the Inquisition at Rome complaining that the Inquisitor at Bologna had made too little of his confessions, and that he had granted him absolution rather as to a lunatic than to a heretic. He actually proposed to come to Rome to be accused in serious form. And not only did Torquato suspect his friends of denouncing him to the Inquisition, but he also accused them of heretical opinions, perhaps founded on some expressions they had used in familiar conversation. The Duke of Ferrara had, indeed, reason not only to be annoyed, but even to be seriously alarmed, for, though the Inquisitor at Bologna took a sensible view of Tasso's revelations, it was by no means certain that the Inquisition at Rome should look upon the matter in the same light. To a shrewd man who took Tasso's whole conduct into consideration he might seem deranged; but the poet possessed a wonderful power of vivid letter writing, and could make his fancies wear plausible shapes. Then the Duke's own mother was known to have been a favourer of the doctrines of Calvin, and some of the taint of heresy might be supposed to cling to Alfonso himself. He had enemies at Rome, and nothing is more credulous of evil reports than hatred. Perhaps they might favour the accusations in the hope of dispossessing him of his principality and causing it to revert to the Papal States, as was actually done after his death. About the same time Torquato wrote to his friend Gonzaga, "Either I am not only of a melancholy humour, but as it were mad, or I am too cruelly persecuted." After ten days' stay at Belriguardo Alfonso sent Tasso back to Ferrara to be treated by his own physician. According to the pathology of the times melancholy was owing to humours rising to the brain. To expel these purgatives were the proper remedy. The poet was far

from being submissive to treatment, and if the doctors did him no good they could always defend themselves by saying that their patient did not carry out their prescriptions. Tasso was kindly received at the convent of the Franciscans at Ferrara, which he repaid by accusations founded upon his ever-brooding suspicions. At another time he avowed his intention of becoming a brother of the Order.

On the 27th of July, disliking the surveillance to which he was subjected, he escaped through the city gate. Managing to elude the horsemen who were sent to pursue him, Tasso appeared in a wretched condition at Poggio, a mansion belonging to the Princess Leonora. The Count Lambertini, who was in charge of this place, sent word to the Princess. Tasso suspecting that he was watched again took flight. How he pursued his way is not certainly known, but after encountering many hardships and dangers he appeared in the dress of a shepherd in his sister's house at Sorrento. Cornelia had been bestowed in marriage by her mother's relations to a gentleman called Marzio Versali. This match had displeased her father, but in the end kindly relations had been resumed. Cornelia's life had not been without misfortunes, and she had even applied for assistance to Torquato in his flourishing days at the Court of Ferrara. She was now a widow, living with her five children. Torquato introduced himself as a messenger from her brother, whom he represented to be at that time in distress and danger. Cornelia showed such visible signs of grief and anxiety that his suspicions about his reception melted away, and he revealed himself as her brother whom she had not seen for twenty-three years. Fearful of his getting into trouble with the authorities at Naples, Cornelia gave out that he was a cousin from Bergamo. With his two nephews Torquato now wandered about that delightful land and revisited the scenes of his boyhood. In this atmosphere of kindness and love the poet's mind seems to have regained tranquillity, though not complete health, as his sister is known to have consulted some physicians of Naples on his account, who disgusted the poet by recommending him to drink salt water. Soon the old unrest returned; he tired of his quiet life with a widow and her children, and longed again for the brilliant Court of Ferrara and the distinction he could not claim under a borrowed name. He wrote letters to the Duke and the Princesses. From Leonora there came a cold reply, and none from Alfonso and Lucretia.

On the 10th of February he was back to Rome, where he found a kind reception in the house of the Duke's agent, whence he sent letters in a very humble strain to Alfonso and the Princesses imploring to be again received into his service. The Duke sent a message that if Tasso wished to return to Ferrara he was content to receive him on condition that he should recognise that he was deranged, and that his suspicions and fancied persecutions came from his humours. This he might conceive from his delusion that he, the Duke, wished to take his life, although he had always favoured him. Had this been really his desire the thing would have been easy of execution. He should make up his mind before he came to consent to allow himself to be cured by the physicians of his humours. The Duke promised to forget the past, but if when he came Tasso did not allow himself to be cured he should be expelled forthwith from the State.

Torquato's pride must have been much abated when he accepted so cold an invitation, but he had found the Duke the most liberal of all his patrons; besides he had in his possession the manuscript of the poem which was to give its author immortality. Some Italian scholars have indeed insisted that we are indebted to Alfonso for the preservation of the *Jerusalem Delivered*, which he refused to give up to the poet, who was spoiling it by his incessant corrections and alterations.

In the summer of 1578 Torquato was again at Ferrara, but not to live over again the happy days of past years. The Duke would not give up his manuscripts; the Princesses would not receive him so readily as before. His suspicions and fears soon found grounds on which to dwell, for he had real enemies as well as fancied ones. He complained that the Duke no longer encouraged him to write verses and wished him to lead an idle life; to become a fugitive from Parnassus in the gardens of Epicurus. In one of his letters Tasso actually says: "Without regard to my health and life I voluntarily aggravated my evil by the disorders of immoderate intemperance so as to put my life in danger." For this he assigns the absurd reason that he wished to gain the favour of the Duke, and to accustom himself to despise health and pleasure, recollecting that it was the opinion of some of the best philosophers that vigorous health is dangerous to virtue, as it assists the body to tyrannise over the mind. Soon Torquato desired to leave Ferrara. This time

he did it with the knowledge of his patron. He now sought the hospitality of the Duke of Mantua, the old friend of his father and his own. At this time Margaret Gonzaga, the Duke's daughter, was making ready to go to Ferrara, to become the third wife of Alfonso. The poet missed the attentions which he expected. With the sale of a ruby ring and a gold collar he raised some money and went to Padua. We next find him at Venice, where Maffeo Veniero thus describes his state in a letter to the Grand Duke of Tuscany, dated 12th July, 1578: "Tasso is here inquiet in mind, and although I cannot say that he is of sound mind, yet the symptoms which he shows are rather those of affliction than of madness. Of his humours the chief one is that he would like to be in the service of your Highness, asking no other provision than as much as will enable him to live in a retired and simple manner. The other is that he wishes the Duke of Ferrara to restore his book to him, of which he has not a copy. On these two subjects he is perpetually talking, and he allows his imagination to run away with him."

Tasso next sought quarters with the Duke of Urbino, where he was received with open arms. He wrote to his sister in grandiloquent terms that he had at last found a reception worthy of his merits. The physicians having prescribed a cautery as a remedy for his mental disorder, a young lady of the Court, Lavinia della Rovere, applied the bandages with her own fair hands. But it was now impossible to keep the poet long content with any situation. He expected on every occasion to be treated with the most marked distinction, and resented any real or fancied slight. Like Rousseau, he was ready to imagine that everyone was thinking of him, and that even his best friends were offended at him or were plotting to injure him. His acute reasoning powers were at the service of his folly to justify his conduct, so that those who were near him got wearied of his perversity, while those who could not watch him closely were disposed to credit his complaints. The rumour that the celebrated poet had become deranged was now widely diffused, and excited a species of curiosity about his doings which made him wroth. His pen was still busy, the sweetness of his verse seemed in no way abated; his conversation had a charm for people of culture, and his pathetic tales of suffering and wrongs excited interest and compassion. Suddenly, without telling anyone of his design, Tasso quitted Urbino and set out for

Turin. Owing to fears of the plague in Provence, newcomers were looked upon with suspicion. He reached Turin on foot, and in such a sorry condition that he was denied admission by the guards at the city gate. Angelo Ingegneri, a printer of Venice, at that time visiting Turin, had known Tasso at Rome. Happening to pass that way he recognised him, and made the guard aware of his distinction. The poet sought the dwelling of the Marquis Philip of Este, cousin of Alfonso, who had married the daughter of Charles Emmanuel, Duke of Savoy, and was in command of his cavalry. The Marquis received Tasso kindly, and the Duke of Savoy showed great pleasure in having so illustrious a poet, and offered to give him as liberal a salary as the Duke of Ferrara had done, and to get back his manuscripts. Had this been accomplished, no doubt Rinaldo, the hero of the *Jerusalem Delivered*, would have been an ancestor of the present King of Italy.

The state of mind in which the poet was at this time is shown in a letter written to the Cardinal Albano then at Rome. He expresses the hope that the Cardinal had not taken offence at his suspicions, since without distinction he had suspected everyone. He at the same time begged that the Cardinal should further add the weight of his recommendation to the Marquis of Este, in order that the Duke of Savoy, his father-in-law, should receive him into his service. The Cardinal wrote in reply imploring Tasso to banish his fears and cease to be distrustful of everybody. "God grant," he goes on, "that you may fully know your mistake, and that it may be a lesson to you in future, and this ought to be the case, as upon my honour, I assure you that there is nobody who attempts, or who even thinks to hurt you in any way; but, on the contrary, everyone loves you, and anxiously desires that you may live; such is your singular worth." He advises the poet to be calm and attend to his studies, and resolve to be governed by the physicians and obedient to the counsels of his patrons and friends. For some time Torquato seems to have had a serene interval, during which he wrote several compositions in verse and prose; but he again became uneasy and applied to Cardinal Albano to procure a restitution of his books and writings, and some gift from the Duke of Ferrara, or a permission for him to return to his service. To this Alfonso replied, as before, that he was still willing to receive Tasso, provided he would allow himself to be treated by the physicians, and would abstain from those reproachful

expressions which during his last residence he had used to some of the courtiers. The Marquis of Este tried to dissuade him from leaving Turin, and promised that he would take him with him in the spring to visit Alfonso; but nothing could prevent him again seeking Ferrara. He was there on the 21st day of February, 1579, at the very time when the whole city was holding festival to give a joyful reception to the bride of the Duke. Tasso, however, did not consider this any reason why he should not be received with distinction, especially as he had composed a beautiful pastoral to read on the occasion. Nevertheless, it does not appear that he was quite neglected. We know that he was received into the mansion of the Cardinal of Este, at a time when all the houses in the city were filled with guests. The sensitive poet, coldly received as he thought by his friends, and derided by enemies, and still denied access to his manuscripts, went to the palace of Cornelio Bentivoglio,* where he found the Countess and other ladies. He now broke out into violent expressions against the Duke, his newly-married wife, and the whole family of Este. Then, in a fury, he hastened to the palace, demanded speech of the Duchess, to solicit that she should get his manuscripts returned to him, that she should save him from the enemies who persecuted him, wished him declared a heretic, wished him dead. The ladies of the Court tried to soothe him, which only provoked fresh invectives and insults. The disturbance increased till the Duke, informed of what was going on, ordered Tasso to be taken to the Hospital of St. Anne, near the palace, where he was put in chains.

This catastrophe happened about the 12th of March, 1579, and, as Dr. Black observes, the same year and perhaps the same month, in which the most illustrious poet of Italy was confined as insane, another epic poet finished, in an hospital at Lisbon, his career of glory and of misery. This was Camoens, the author of the *Lusiad*. It is likely that the Duke, with more pleasant matters to engage his attention, took little trouble to direct how Tasso should be treated. The ordinary methods of dealing with the insane in those days were rough and hard. Their violence should be tamed by darkness and starvation, or quelled by blows. Shakspeare in *As You Like It* gave the current view: "Love is merely a madness; and, I tell you, deserves as well a dark house and a whip, as madmen do; and the reason why they

* Solerti, *Vita*, Vol. i., Cap. XVI., p. 309.

are not so punished and cured is, that the lunacy is so ordinary, that the whippers are in love too."

No such indignities were offered to the unfortunate poet, though for a time he was kept in strict confinement. His mental derangement did not prevent him being fully aware of his own misery; indeed, with his powerful imagination and highly cultivated presentive faculties, the hardships which surrounded him were augmented by bitter regrets from the past, and vivid fears for the future. Shortly after his imprisonment he writes to his faithful friend Gonzaga, that after all his bright hopes of gaining eternal fame from his poems and finishing his life in honour and glory, he now only desires like common men to lead a life of liberty in some poor cottage, if not in health, for that may no longer be, at least free from such distressing sickness, if not honoured at least not abominated. "I do not fear," he goes on, "so much the greatness of the evil as its duration, which appears horrible to my thoughts, especially as I know that in such a state I am neither fit to write nor to work. The fear of perpetual imprisonment and also the indignities used towards me much increase my melancholy. The squalor of my beard, and hair, and dress, and the sordidness and filth much annoy me, and above all I am afflicted by solitude, my cruel and natural enemy, from which even in my good estate I was so troubled that I went seeking company at unseasonable hours. Sure am I that if she who has so little corresponded to my attachment, if she saw me in such a state and in such affliction, she would have some compassion on me." Dr. Black reproaches Serassi with disingenuousness in suppressing this last sentence, which seems to refer to the Princess Leonora. It is certain that even during Torquato's life there was a widespread rumour* that the cause of his mental alienation was an unhappy passion for this lady. His long imprisonment was thought to be owing to the deep offence taken by Alfonso at the presumptuous love of Tasso, which he was said to have shown by kissing the Princess at some entertainment.

Black tells us that "not only Milton, but every writer since the time of Manso (whether Italian or foreigner), by

* Black, Vol. ii., p. 78, tells us that J. Eliot in his *Orthœpeia Gallica*, printed in 1593, speaking of our poet, says, "This youth fell mad for the love of an Italian lass descended of a great house, when I was in Italy." A similar report was made by Bartolomeo del Bene, a Florentine residing at the Court of Henry III. of France. Solerti, Vol. i., p. 378.

whom Tasso is mentioned, continued to attribute his misfortunes to his passion for Leonora." It was a further growth of this legend that the poet's insanity was an invention of the Prince of Ferrara to serve as an excuse in the eyes of the world for the cruel treatment to which the victim of his pride was subjected, or if Tasso's mind ever wandered, that it was owing to his sufferings during his imprisonment. The truth is Tasso always thought more of his own fame than of any woman, and at this time his mind was engrossed with other cares. He had now known Leonora for about fourteen years; he was thirty-five and she was forty-two. The Princess died about two years after. A volume of verses celebrating her virtues and bewailing her death came from the rhymers of the Court, but it does not contain anything from the pen of the great poet who, through the association of their names, has saved that of Leonora from oblivion.

A gloomy vault in the hospital of St. Anne's is still shown to visitors as the place in which the poet was confined. Solerti proves that this is an invention no older than the present century, and that the place was nothing else than the old coal cellar of the building. Tasso complained bitterly of the rigid and even cruel manner in which he was treated by the Prior of St. Anne's, Agostino Mosti, adding that he received affronts from the attendants. He also accused the Prior of using magical arts against him. He wrote piteous letters to the Duke asking forgiveness of the insulting expressions he had used, which he said never came from his heart. In the month of May he was shifted to better quarters. In the court register there are entries for butter and eggs regularly supplied to *Signor Tasso ammalato*, and also for furniture; his clothes, books, and other belongings were sent to St. Anne's, where he seemed to have had two rooms.

Tasso confesses having struck one of his keepers, but so much seems to have been made of it that we may judge that he was seldom violent. At first he was in a state of deep dejection. "My head," he wrote, "is always heavy and often painful; my sight and hearing much impaired, and all my frame is meagre and exhausted. My mind is sluggish to think; my fancy slow to imagine; my senses dull to convey the images of things; the hand is heavy in writing, and the pen seems as if it shrunk from its office; in everything I am benumbed and plunged into an unwonted

stupor." His mind seems to have become more settled at the end of June, 1579. He now received visits from his friends, and busied himself with his poetical compositions. Amongst these are some beautiful and pathetic canzoni to Alfonso and his sisters imploring to be set free. He wrote to many powerful and distinguished personages in Italy asking them to intercede for him with the Duke of Ferrara, but all in vain.

When a man of sufficient worth to excite envy falls into straits, there are always people malicious enough to rejoice in his misfortunes, and generally others mean enough to make profit out of them. In his fastidious desire to get every blemish removed from the *Jerusalem Delivered* he had sent copies all over Italy for the emendations of critics, not without dire misgivings that the sheets might fall into unworthy hands, and so it came about that one Malaspina, a man of notoriously bad character, had got hold of a truncated copy which, hearing of Tasso's imprisonment, he, flying from the gallows at Florence, ventured to publish at Venice in 1580. Thus after his three years' fretting and troubling with the critics the helpless prisoner of St. Anne's saw his great poem given to the world in an incorrect and mutilated form. In this matter, however, Tasso's friends were able to help him. Angelo Ingegneri, the printer of Venice, had in 1579 made a copy of the *Jerusalem Delivered* at Ferrara in six nights. He now brought out two editions, one in Parma, the other in Venice, which, as stated in the preface, were revised by the author. The work spread with a blaze of glory. In 1581 there appeared seven editions, and six the next year. From every part of Christendom men of culture and literary taste turned their eyes to the Asylum of St. Anne's. Had Tasso published his poem when it was completed three years before, he might have gained large sums. As it turned out, while publishers and friends were making money out of his work he did not receive a farthing. The *Aminta* and several of his prose works now also became the spoil of the printers.

It was about this time that Michael de Montaigne visited Tasso, and thus wrote of him in his essays* "I had more vexation than compassion to see him at Ferrara in such a piteous state, surviving himself, forgetting both himself and his works, which without his knowledge, and certainly without his seeing them, have been published incorrect and out

* *Essais*, Liv. ii., Chap. xii.

of shape." Tasso, who was one of the openest of men, describes some symptoms significant of mental derangement.

In a letter to his friend Maurice Cataneo, Secretary to Cardinal Albano, dated 18th October, 1581, he relates the disturbances which he experienced in studying and in writing. "Know, then, that these are of two sorts, the human and the diabolic. The human are cries of men, and particularly of women and boys, and derisive laughter, and divers voices of animals which are excited by men to disturb me, and noises of inanimate things which are moved by human hands. The diabolical are enchantments and witchcraft, but of the enchantments I am not certain, because the rats, of which the chamber is full, and which seem to be possessed by demons, may be the cause of the noise, and some other sounds which I hear may be referred to human artifice. Nevertheless, it appears to me to be quite certain that I have been bewitched, and the operations of witchcraft are very powerful. I recognise that when I take a book to study, or a pen to write, I hear voices sounding in my ears, among which I distinguish the names of Paolo, Giacomo, Giralomo, Francesco, Fulvio, and others, who perhaps are malicious persons and envious of my quiet, and if they be not such they would act courteously to remove the bad opinion which I have conceived of them on account of their evil arts. At that time also, more than in any other, many vapours ascend to my head, often before eating, so that my ideas are much disturbed." He further observes that in addition to these impediments there are often internal ones. He is moved to extreme anger, and tears up his letters before they are finished. Though his memory has been greatly weakened, he thinks that after the use of cathartics and such nourishing food as would not increase the melancholy humours, he would be able to accept the office of Secretary, or if he could get enough of money from the sale of his writings to keep him, he would think of nothing but his studies, and this not so much from the hope of glory as from the desire of quiet.

In 1583 Tasso wrote Jerome Mercuriale, Professor of Medicine in the University of Padua, asking his advice. He thus describes his disorder: "For some years I have been infirm of a disease the nature of which is unknown. Nevertheless, I am convinced that I have been bewitched. But whatever is the cause of my malady, these are the

effects: Gnawing pain in the intestines and bloody flux; sounds in the ears and head, sometimes so strong that it seems as if there were a clock within it. Images of various things, always displeasing, so disturb me that I cannot apply my mind to study for three or four minutes, and the more I strain my attention the more I am distracted by various imaginations, and sometimes by violent bursts of anger, suddenly excited by the divers phantasies which arise in me. Besides, always after eating my head fumes beyond measure and gets very hot, and in everything which I hear my fancy mingles some human voice, so that it appears that inanimate things speak to me, and my nights are disturbed by various dreams. Sometimes I am so carried away that I seem to have heard, or if I may not say I have assuredly heard, some things which I have communicated to Father Marco a Capuchin, the bearer of this letter, with other fathers and laics with whom I have spoken about my malady, which being not only great but most painful, has need of powerful remedies, and although no better remedy may be expected than what comes from the grace of God, who never abandons those who firmly believe in Him," nevertheless he would be grateful for advice from the learned physician. Mercuriale advised a cautery in the leg, that he should drink only broth, and abstain entirely from wine. He promised to send a conserve which had much efficacy to sweeten the blood and allay the fumes, so that they should not rise to the head. The poet considered these prescriptions insupportable, but was willing to try the conserve if it had a good taste. There were times when the excitation of his nervous system abated, his mind became calmer, and his powerful intellect exerted itself against the delusions that beset him. In a prose work called *The Messenger*, written in 1580, Tasso holds a dialogue with a spirit, who pretends that he has paid visits to him for four years. The poet expressed his doubts whether the apparition had a real existence, which so much offended the spirit that he said: "Were it not that the charge of thee is entrusted to me by one whom I must obey, I should even be disposed to leave thee." Torquato, still incredulous, observes that "Though this be not the imagination of a man who sleeps, it may be that of a man who wakes, but is a prey to phantasy. There are certain alienations of mind which no less than dreams can represent falsehoods as truths—nay, can effect this with

still greater energy, since in sleep only the sentiments, in madness the whole reason is chained." Better had it been for the poet had he kept the strength of mind to apply such principles. In another letter to Cataneo, written at the close of the year 1585, the poet tells his friend how one of his letters had disappeared, no doubt carried away by a Folletto or sprite who stole his things, set on by some magician. "Of this, indeed," he goes on, "I have many proofs, especially from a loaf of bread taken visibly away from before me an hour before sunset, and a plate of fruit taken away the other day when that young Polish gentleman, worthy of so much admiration, came to see me." Gloves, letters, and books taken from locked chests were sometimes found in the morning on the floor. Other things which went a-missing when he was absent he sagaciously supposes might have been taken by men who, he verily believes, have the keys of all his trunks. Believing in witchcraft and devils, like most men of those times, Tasso was disposed to assign anything he could not readily explain to their agency, and some of the inmates of the hospital took advantage of his simplicity. Further on in the letter he gives a vivid description of the disturbed state of his nervous system.

"Besides these miracles of the Folletto there are many nightly terrors, because even when awake it seemed as if I saw flames in the air, and sometimes flashes of light, so that I dread the loss of sight, and sometimes sparks visibly issue from my eyes. I have also seen in the middle of my tent-bed shadows of rats, which by natural reason could not be there. I have heard frightful noises, and often in my ears I hear sounds of hissing, tingling, ringing of bells, and the ticking of a clock, and often there is a beating for an hour, and when asleep it appeared to me as if a horse threw himself upon me, and I felt myself much relaxed. Amidst so many terrors there appeared to me in the air the image of the glorious Virgin, with her Son in her arms, in a halo of coloured vapours, so that I ought not to despair of her grace. And though this might easily be a phantasy, because I am frenetic and always disturbed by various phantasms and full of endless melancholy, nevertheless, by the grace of God, I can sometimes *cohibere assensum*, which shows the operation of a sound mind, as Cicero observes, whence I may rather believe that it was a real vision of the Virgin."

Solerti quotes two physicians who knew Tasso's case by

report. One mentions the necessity for his detention and his perpetual conversations with a spirit (*cum numine quodam*). The other describes his hallucinations and melancholy. In reply to a petition from the Cardinal Albano that as soon as possible Tasso should be allowed his liberty, the Duke replied through his minister* that leave had been given to Tasso to take the air in the gardens and to go about Ferrara, but this had done him no good. He had got so furious that it was difficult to get him back to the hospital. The Duchess Lucretia had taken him to Belvidere, but he had terrified her by his violent behaviour. He, Alfonso, at the intercession of the Duke de Joyeuse, had allowed the poet a little more liberty, and had admitted him to his presence, but he seemed to have a brain weak and unstable, and he was oppressed with melancholy, and it might be said only had lucid intervals when he was writing poetry, which he did through a certain natural inclination. The doctors of Ferrara had despaired of his recovery.

Torquato's old friends did not forget him, and his poems gained him new ones. Men of distinction came to visit the poet of the Crusades within the walls of St. Anne's, and he received presents of books and money, much of which was stolen from him. This growing fame no doubt inclined the Duke to pay greater attention to his unwilling guest. Yet one of the most devoted of the poet's admirers—the Father Angelo Grillo—was constrained to admit that Tasso's imprisonment was rather due to the affection than the hardness of the Prince. Thus while learned academies were hotly disputing whether Ariosto or Tasso were the greatest of the Italian poets, while the *Jerusalem Delivered* was read throughout Europe, even in England, so slow to recognise the genius of her own great dramatist, Tasso was quoted as the third great epic poet, years came and passed away, and he was still a wretched prisoner in the asylum of St. Anne's. He had gained the glory which he sought, but it came to him embittered by the pity and contempt of those in whose power he was placed. His fine imagination had become his torment, and his wonderful capacity to recognise the beautiful and picturesque was matched with a keen sensibility to suffering.

Tasso sent many pathetic petitions in prose and verse to Alfonso, and was unwearied in stirring up his friends to intercede for him. He wrote to all the Princes of Italy, to

* See the two letters of John Baptist Laderchi in Solerti, *Vita*, Vol ii., p. 217.

the Magistrates of Bergamo, to the dignitaries of the Church, to the Pope, to the German Emperor, imploring their help to set him free.

It is likely enough that the Duke, known to be very jealous of his power and position, should be offended by appeals made over his head to these potentates. It may in some degree account for his obstinacy in resisting so many petitions to try whether more liberty could not be allowed to his poor prisoner. It seems that there was some improvement in Tasso's mental state. His religious terrors and doubts had sunk into the quiet of implicit faith, and his fits of excitement were fewer and less marked. This may have made Alfonso at last to yield to the entreaties of Vincenzo, son of the Duke of Mantua, and allow Tasso to leave Ferrara in his keeping. He was thus set free, on the 5th of July, 1586, after a confinement of seven years and two months.

When one recalls the long series of learned biographers and historians who have followed one another in proclaiming Tasso as the victim of the pride or resentment of the Duke of Ferrara, he may well conceive that there is a form of lunacy which consists in readily harbouring the notion that when persons are treated as insane they are only the victims of perfidious relatives, curators, or doctors given to paradox. The need of utterly rooting out this delusion has made not a few passages in Solerti's biography to look hard and unsympathetic. On the other hand the character of the Duke of Ferrara comes brightly out of the accusations so long entertained against him. It looks to us, indeed, as if the restraint put on the unfortunate poet were needlessly severe; but we do not know all the circumstances, and Alfonso acted under the advice of his physicians. Altogether there appears no reason to believe that towards Tasso he ever acted save under the best desire for his welfare. During the remaining years of the poet's life he never required to be deprived of his liberty, yet he never was restored to complete sanity. Solerti shows that now and then there were outbreaks of violent suspicion or unreasonable rage.

At Mantua the kind and delicate attentions of the ducal family and the joy of freedom soothed his troubled mind. For a time everything seemed pleasant. He showed a prodigious literary activity, and had a physician who gave him medicines in confections to strengthen the memory. Though he was allowed to go freely about Mantua Tasso

soon noticed that a watch was kept over his movements. The Duke was bound by an engagement to send him back to Ferrara should Alfonso require it. Tasso's fears and suspicions returned, and one day, hearing that the Duke of Ferrara was expected at Mantua, he took flight and set out on foot for Loretto, to pray for the intercession of the Virgin for his restoration to health. He reached Loretto wearied and penniless, and might have fared badly had a friendly nobleman from Mantua not been there at the same time, who lent him money and introduced him to the Governor of the town.

The remaining eight years of Tasso's life were passed wandering about Italy in search of a patron who would give him lodging, salary, and entertainment in his palace in return for laudatory verses and dedications of his books. The same story is repeated again and again. The poet is received with distinction, sits at table with princes and cardinals, and holds converse with the literary men around. Then as the marks of admiration subside, and he tires of the situation, he conceives that he is slighted, or suspects that plots are being hatched against him, and precipitately departs, often leaving books and other effects behind him, which cause him much distress in reclaiming. The intermittent fever returned again and again, and he had several serious illnesses. He was not careful of the sums occasionally bestowed upon him by his friends or gained by his venal verses, and sometimes got into great straits. When none of the palaces of the great were open he would find a lodging in a monastery, and on one occasion the greatest of the name was reduced to take refuge in an hospital founded at Rome by the Tassos of Bergamo. He wrote and published many works in prose and verse, but though they were read at the time and some of them contain fine passages, none bear the stamp of immortal genius like the poems of his youth. His strangest literary effort was the *Gerusalemme Conquistata*, the *Jerusalem Conquered*, published at Rome in 1593, which was designed to supersede the *Jerusalem Delivered*. Finding that the literary public thought it an inferior poem he wrote a treatise to show that they were mistaken. We have not read this second epic, and are content to accept the opinion of Dr. Black that it was merely a bad copy of the *Iliad* in which Jerusalem takes the place of Troy, the Greeks become the Crusaders and the Trojans the Mahomedans. Roncoroni, who compares the two poems,

tells us that in the *Jerusalem Conquered* there are many fine passages, sometimes more happily expressed than in parallel ones of the *Jerusalem Delivered*.

Though Tasso became estranged from some of his old friends, on the whole we wonder at their fidelity; nor did he fail to make new ones. John Battista Manso, the Marquis of Villa, enjoyed the double honour of being in his youth the friend of Tasso and in his old age the friend of Milton. The earliest of the biographers of the Italian poet, he has left an affectionate record of his virtues, which we are in danger of forgetting in describing his mental derangement.

Tasso was frequently entertained by Manso in his beautiful villa by the shore of the Bay of Naples, and in the autumn of 1588 he went with the Marquis to visit his feudal town of Bisaccio.*

The following letter written by Manso to a friend shows that the poet could still enjoy the pleasures of life:—"The Signor Torquato has become a great hunter and overcomes the roughness of the weather and of the country. We spend the bad days and the long hours of the evening in hearing music and singing. He takes great delight in listening to the improvisatori, whose readiness in versifying he envies. Sometimes we dance with the girls here. This pleases him

* Solerti argues, *Vita*, Vol. i., p. 613, that the story of Tasso's accompanying the Marquis of Villa to Bisaccia and the particulars given in the text with other picturesque incidents, are but a romantic invention of Manso's. Roncoroni, citing the same passages, briefly says that he does not consider that Solerti has proved his point (*Genio e Pazzia in T. Tasso*, p. 48). Out of respect for the learned biographer I give my reasons for upholding the veracity of Manso. Solerti informs us that Modestino affirmed that Manso was never feudal lord of Bisaccia, and cited legal documents to that effect. Moreover it appears from letters of Tasso dated Naples that he was in that city on the 6th and 16th of September, on the 24th and 31st of October, and on the 2nd, 3rd, 4th, 9th, 14th and 24th of November.

We know, however, that Manso's right to be lord of Bisaccia was the subject of a contested law suit, and Solerti himself observes that some of Tasso's letters to the Marquis were directed to Bisaccia, and in the title of his *Poesie Nomiche* Manso is styled *Signor della Città di Bisaccia e di Pianca*. The same title is given to him in the frontispiece of Manso's *Vita di Torquato Tasso*, dedicated to the Duke of Urbino, and published with license at Venice in 1621, while Manso was still alive. The claim of Tasso to have a spirit with whom he held converse is made in other passages of his prose and poetical works.

Respecting the date of Tasso's visit to Bisaccia, which is fixed by Serassi as occupying the whole of October and part of November (up to the 8th), the time is not definitely stated in Manso's *Vita* (see pp. 138-144 and 195-196). We gather that it was towards the end of the autumn of 1588, and that it did not last long (per non multi giorni); thus it may have occupied the days between the 10th and 24th November. Besides, people sometimes date their letters from the place where they have a fixed address, especially if they only expect to stay a short time at the place whence they are writing.

much. A good part of our time we spend sitting by the fire talking, and we often fall into reasonings about the spirit who, he says, appears to him, and he has talked about it in such a way that I do not know what to say nor what to believe."

To some arguments redolent of the demonology of those times, Tasso replied that he believed in the reality of these apparitions from the long time during which he had seen them, and from the conformity which he has always observed in them, a thing which could not continue if the things seen by him were not actual, but the figments of the foolish imagination of his fancy. A similar defence has been made of the visions of Swedenborg. One day Tasso said to his friend:—"Since I cannot persuade you with reasons I shall convince you by experience, and shall cause that you with your own eyes see this spirit, about whom you will not lend faith to my words." I accepted the offer, and the following day as we were sitting by ourselves near the fire he turned his eyes towards the window, and kept gazing so fixedly that he gave no answer when I called him. 'Behold,' he said to me, 'the friendly spirit who tries courteously to talk with me. Lift up your eyes, and you will see the truth of my words.' I directed my eyes thither immediately, but look as hard as I could I saw nothing save the rays of the sun which shone into the chamber through the window-panes. And while I thus turned my eyes around seeing nothing, I heard that Torquato had entered into lofty reasonings with whomever this might be. Although I heard and saw nobody save himself, nevertheless his words at one time proposing, at another answering, were such as those who were reasoning closely upon some important matter, and from what came from him I easily conceived what the replies were, although I could not hear them." After this converse had gone on for a while the spirit was understood to depart, when Manso goes on:—"Torquato, turning to me, said, 'From this day all your doubts will have disappeared from your mind,' and I replied, 'Rather are they increased, and since I have heard many wonderful things and have seen nothing of what you promised to show me to make my doubts cease.' And he, smiling, rejoined, 'You have seen and heard more of him than perhaps—' and here he stopped."

With the passive consent of the authorities Torquato was allowed to live in Naples, where he commenced a lawsuit

along with his sister for the recovery of their mother's portion, and got an excommunication from the Pope against those who unrighteously withheld it. There was some difficulty in tracing to whom it had gone; at last a suit was issued against the Prince Avellino, who had become heir to Torquato's maternal uncles. Amongst other means used to delay or impede the proceedings the Prince pleaded that Tasso could not be a plaintiff as he was insane, but this objection was not entertained. Better days seemed now to be dawning upon the unfortunate poet. The Prince of Avellino, after a long litigation, during which Cornelia died, agreed to pay 130 scudi, about £38 of our money, yearly during Torquato's life. Besides this, the Pope Clement VIII. promised him an annual pension of 200 scudi = £59, and invited him to Rome that he might be publicly crowned as poet laureate in the capitol, as Petrarch, a happier bard, had been 253 years before. Tasso was invited to Rome by the Cardinal Cynthia, the nephew of the Pope, to prepare for the ceremony. In his younger days he was fond of the pageantry of Courts, but now he felt that his triumph had come too late. On a friend reading him a sonnet upon the approaching ceremony he quoted a line of Seneca: "*Magnifica verba mors prope admota excutit.*" He asked to be conveyed to the monastery of St. Onofrio, telling the monks he was come to die amongst them. The prior and the monks gave a kind reception to their illustrious guest, but the fever could not be checked. On being told by the Pope's physician that his end was near Tasso gave thanks to God "that He had now brought him to a harbour after so dreadful and tempestuous a voyage." A short time before the end the Cardinal Cynthio* brought Tasso the benediction of the Pope, and asked if he had any request which they could carry out for his satisfaction. He replied that he desired to be privately buried in the church of St. Onofrio, and since God had not permitted him to complete his poem of the *Creation of the World* he begged the Cardinal that this and all his other works (especially the *Jerusalem*, the most imperfect of all) should be burned. He knew this to be a great favour, as his writings being scattered in many hands it would be a hard task to collect them, nevertheless he hoped the thing was not impossible. He urged this strange request with so much earnestness that the Cardinal, fearing to distress him if he contradicted or refused his petition, answered that if the thing could be done

* Manso, *Vita*, p. 231.

in any manner orders would be given to put his desire into execution. This was a pretty safe answer to give. We are told that Virgil prescribed in his will that the *Æneid* should be burned, as he did not wish it to go to the world without farther correction, and perhaps Augustus could have laid hands upon every existing manuscript of the *Æneid*; but how could any man collect all the copies of the *Jerusalem Delivered*, which were already scattered over the whole world from above twenty editions? He expired on the 25th of April, 1595, aged 51 years. His tomb is still to be seen in the church of St. Onofrio.

The life of Torquato Tasso falls into three periods. In the first we have a young Italian poet, brave and beautiful, going forth in the full enjoyment of his fine gifts and the pleasures of the world, but much higher than a mere voluptuary, seeking the loftiest themes for his verse like a singing bird in a lovely spring soaring high in the sunshine. Then strange thoughts and cruel suspicions intruded into his mind; a cloud of melancholy overshadowed him; his delirium hurried him into extravagances till he found himself within the dark walls of the Asylum of St. Anne's; outside a fame which extended throughout Europe, and inwardly vexed by mental distress, bodily weakness, frenzied fancies, uttering piteous supplications for freedom, mingled with cries of impotent rage. After seven years the locked doors are opened, and there issues forth a man bearing a famous name, but how much changed from him who wrote the *Jerusalem Delivered*! We do not know the character of a man from his delusions, yet insanity always leaves its stamp upon a man's character. That of Tasso was naturally a lofty one, and even to the last he presented a certain dignity and grandeur like some great man-of-war with bare decks and broken masts tossing rudderless about upon a stormy sea, but still in her giant bulk and lofty build showing proof of a high destiny. Proud of the nobility of his race and prouder of his genius, Tasso looked down upon the vulgar, the plebeian, but he had to bend his head to the great, for his early education and the necessities of life made him a courtier. He could not endure a dull and unpicturesque life. To the end of his days he longed to get back to the Court of Ferrara. His love of fame never led him to envy. He never decries any other poet. Apart from his insane fits of suspicion he spoke ill of nobody, and rather bewailed persecution than resented it. His friend Manso says that Tasso had the entire possession

of all the moral virtues, and goes through these virtues with the precision of an inventory. Solerti treats the description given by Manso as the invention of a fond friend and enthusiastic admirer of his poems, but Manso knew the man, had conversed with him, lived with him, saw his goings out and comings in, and why should he have taken the trouble to make a portrait which bore no resemblance? Solerti's depreciation is taken entirely from a number of letters and other documents describing some striking events in Tasso's life. It is impossible to read his writings without recognising that his heart was warmed by the loftiest piety and by a noble morality. He was naturally courageous, truthful, and honourable in his dealings. The fruits of his genius and labour were snatched from him by others, and his carelessness of money and shifty manner of living often reduced him to painful straits. Poverty and dependence insensibly degrade the proudest, and during the last years of his life Tasso's heaven-born gift of song was turned to shabby uses. He reminds one of the description of an old lion through decay of strength unable to spring upon the stag and pull down the buffalo, seeking to stay his hunger by preying upon rats and other weakly creatures. He was ever seeking for a Macænas amongst popes and princes and cardinals who should give him lodging in their palaces, should admit him to their banquets and give him fine raiment; at other times he was glad to seek a lodging in monasteries and borrow scudi to pay for his pressing wants. He was ready at every marriage, birth, baptism, or death to write a canzone or a sonnet, and his praises were measured not so much by the merits of the person celebrated in his verses as by the expected reward: so much for being compared to Hercules, so much for being compared to the sun, so much for figuring in the *Gerusalemme Conquistata* as a valiant and magnanimous champion. Sometimes the same sonnet dedicated to one person is, after a time, with slight changes, sent to another. But we need not forget that Tasso was not the only poet who sold his praises, and from any large library of English authors of the last century we could pluck out a sheaf of fulsome and servile dedications which can now scarcely be read without disgust. In general Tasso was temperate in his diet, though fond of fine wines. The purity of his manners is striking,* especially if we consider his wandering and un-

* Fui da bocca di lui medesimo rassicurato, che dal tempo del suo ritegno in Sant' Anna, ch' avene negli anni trentacinque della sua vita, e sedici avanti la morte, egli interamente fù casto.—Manso, *Vita*, p. 265.

settled life, though perhaps the weakness of his health often saved him from temptation.* His confessor said that for many of the last years of his life he was guiltless of any mortal sin.†

Tasso's published writings, which fill twelve volumes quarto, give us a measure of his intellectual power. The precocious maturity of his mind is remarkable. There is no other instance on record of so fine a poem as the *Rinaldo* being produced by a young man of eighteen. When we come to his poems all is beauty, order, and regularity. There are no uncouth bursts of passion, no attempt to become striking through the bizarre or the paradoxical. If one were asked from a perusal of the works of Ariosto and Tasso who of the two poets was insane, he would surely say Ariosto. Opinions vary as to the relative rank to be assigned to the *Jerusalem Delivered*. Some critics place it equal to the *Æneid*, others a little below it. Voltaire in his essay on "Epic Poetry" has pronounced the *Jerusalem* to be the best epic we have. A question like this will not readily be settled. The Latin races have not the same taste in poetry as the Teutonic ones. The Italian language is not much studied in this country, but there are at least eight translations of the *Jerusalem Delivered*. Fairfax's is the most vigorous; Hoole's the most polished. As far as enduring fame goes Tasso might have died at thirty-five; but even after he left St. Anne's he wrote some fine poetry. His poem *Del Mondo Creato* is said to have made Milton conceive the idea of *Paradise Lost*. Tasso was a man of great breadth of mind and varied attainments. A student all his life, he was well acquainted with French and Spanish as well as Latin and Greek. "The prose of Tasso is placed by Corniani almost on a level with his poetry for beauty of diction."‡ He has a flowing and lively style, though sometimes turgid and affected with conceits, and his thoughts are just and penetrating. He was well read in Greek philosophy, especially in Plato's works. In handling philosophical subjects he brings a subtle and penetrating intellect. As a critic he shows much justness of taste; his remarks on the structure of the *Iliad* and *Æneid* are noteworthy, coming from a master of the poetic art. Throughout all his writings

* He writes in one of his letters: Non avendo l' animo inclinato a le nozze, ed essendo quasi inabile al matrimonio, e di debole diventato impotente, penso a gli onori ecclesiastici.—Solerti, Vol. i., p. 584.

† Manso, p. 230.

‡ Hallam, *Literature of Europe*, Vol. ii., Chap. VII., Sect. I.

Tasso keeps the same stately and serious style, never passing into the comic. Manso has a collection of his best sayings; none of them are remarkable for wit, not even those which were published before he was born, for some of them are not original.

The tardy admission that Tasso was insane has been gained by the studies of some eminent Italian physicians at last prevailing against the statements of indolent historians and biographers. It is probable that the accumulation of evidence in Roncoroni's work, *Genio e Pazzia* in Torquato Tasso, will prevent any relapses into old errors. Dr. Roncoroni, who dedicates his book to Professor Lombroso, considers the question of the connection of genius and insanity. We have had much loose writing about genius being a neurosis, or that nervous diseases and insanity are more common in the families which produce men of genius. Roncoroni says he appeals to facts; but there are more false facts in the world than false theories, and the apocryphal anecdotes quoted about celebrated men in some popular books on this subject are enough to throw discredit upon the whole conception. Has it ever been proved by exact comparative inquiry that a given number of men of unquestionable genius have in their ancestors, descendants, and collaterals more nervous diseases and insanity than the same number of ordinary men living under similar conditions?

The word genius has been used to cover many kinds of capacities. The genius of a great general, or mathematician, or poet, or historian, or painter, or musical composer, implies the possession of a greater or lesser number of different faculties in vigorous action. The man of genius only possesses in heightened power capacities which all men of sound mind have in lesser degree. We suppose that genius is a born aptitude to perform some things much better than most people can, and that it is largely dependent upon greater perfection of organisation and brain function. Such capacities are no doubt likely to lead to over-strain, and the example of Tasso proves no more than that men of high poetical genius are not exempt from mental derangement. Insanity, however, is fatal to genius and to all high mental and moral endowments. We have seen that Tasso's insanity increased his sensibility to painful impression, weakened his memory, diminished his power of concentration, injured the balance of his judgment, perverted his taste, lessened his self-control and moral rectitude, and removed the restraints in the way of his morbid egotism, or,

in other words, these deductions from or perversions of his normal power were the symptoms of his mental derangement. It is difficult to say in what class of insanity Torquato Tasso should be placed. The older physicians treated it as melancholia, and this is so far correct that the affective faculties seem to have been the first to be deranged and the most disturbed. Corradi makes it to be alternating or circular insanity, and Roncoroni finds in Tasso all the marks of paranoia. This is to me by no means clear. Hereditary predisposition seems wanting, and the marks of degeneration are rather hastily assumed; there does not seem to have been a progressive increase in the malady after the first years of his imprisonment in St. Anne's. Nevertheless some of the symptoms, the exaltation, the delirium of persecution, and the hallucinations and delusions are such as go to make up the picture of paranoia as described by Italian alienists.

The main cause of so prolonged a controversy no doubt was that Tasso's mental derangement never was accompanied by such a complete submergence of the intellectual faculties as is looked for in the vulgar idea of madness. He was subject to fits of delirium which, when they passed away, left him in possession of much intellectual power, and this enabled Manso to say that his infirmities never passed the bounds of delirium occasioned by melancholy. Thus his friend Manso considered him to be sane, though subject to melancholy and occasional illusions; but he lets us know that Tasso's enemies called him mad.

In the life-course of this gifted but unfortunate man the mingling of great talents and great sufferings, high honours and deep humiliations, constitutes the most pathetic biography known to us in the whole history of literature.

CLINICAL NOTES AND CASES.

A Case of Recurrent Mania. By JOHN G. HAVELOCK, M.D.,
Senior Assistant Physician, Montrose Royal Asylum.

The following case of recurrent mania presents many features of unusual interest. The patient is a merchant, who in the course of the last thirty-four years has had twenty attacks of acute mania, and in the intervals has successfully managed a large business. At the present time he is perfectly well both mentally and physically, having

had a long period of immunity from the disorder. This improvement is ascribed by the patient himself, with some degree of probability, perhaps, to his having taken most enthusiastically to bicycling, or, if we may so term it, "become affected with cycling-mania."

First Attack.—Mr. A. B., a merchant, was first admitted to Montrose Asylum in 1862. He was then in his twentieth year, had received a good education and was actively engaged in business. He had always shown an excessive literary ambition, and for some time had been composing poetical effusions of a socialistic tendency, making this the sole recreation of his leisure moments. His habits were strictly temperate in all respects, and the family history was good with the exception that three sisters had died of phthisis. On admission he is described as a tall slender lad of delicate appearance, but with no evidence of bodily disorder. He was labouring under a mild form of excitement, but was able to control himself with an effort. Soon, however, he became acutely excited, walking about in a restless manner, holding his head with his hands, staring at himself in the glass, singing, and repeating verses of Psalms for hours on end, though at times he was unduly taciturn. In the course of a few weeks the excitement abated, and he made an excellent recovery after five months' treatment.

Second Attack.—Patient kept quite well after the first attack until eleven years afterwards when he had reached the age of thirty. Since his former attack he had continued his literary pursuits, chiefly in secret, employing every spare minute he had with them. His writings had consisted mainly of poetical effusions advocating schemes for effecting some great social reforms. On admission he laboured under suppressed excitement, would speak to no one, and would allow no one to meddle with him. Gradually became restless and talkative as in the former attack, and continued so for several days. Recovered in the course of three weeks.

Third Attack.—In November, 1884, he came as a voluntary patient. Was excited, verging on acute mania, abrupt and flighty in manner, conversation spasmodic and disjointed. When alone he recited poetry and danced about, but restrained himself in company, though it evidently cost him a great effort to do so. Was perfectly conscious of his own state, which he termed "hysteria, brought on by over-work." Continued excited for some days and returned home at the end of a month.

Fourth Attack.—Five weeks after the end of the last attack Mr. A. B. again sought admission as a voluntary boarder. He turned up at the Christmas ball evidently labouring under suppressed excitement, and in the course of the evening became much worse, continuing excited and restless for some days afterwards. After this improved rapidly, and returned home at the end of the month.

Fifth Attack.—This came on in March, 1885. On admission he was restless, incoherent, refusing to answer questions, wandered about aimlessly, fingering pictures, and making odd gesticulations with his hands, singing and repeating verses of Psalms. Gradually recovered after two months' treatment.

Sixth Attack.—This began in November, 1885. Was admitted as a voluntary patient, and after passing through an attack similar to the one last described, was well enough to return home after two months' residence.

Seventh Attack.—In May, 1886, again came as a voluntary patient. When admitted was able to control himself, but soon became excited as on former admissions. A few days afterwards the attack had reached its height, and he was extremely excited, making extraordinary gestures, throwing himself on the ground and rolling about, shouting and speechifying incoherently, holding his head, blowing, and going through innumerable antics. Had bad nights, was destructive, and too restless to take his meals. In the course of a month had quite recovered.

Eighth Attack.—This was a comparatively mild seizure in the winter of 1886-87, which was treated at home with the assistance of a trained attendant.

Ninth Attack.—In May, 1887, was again admitted in a state of acute mania, violent and unmanageable. Literally raving, shouting, stamping, declaiming and gesticulating in an extraordinary way. Discharged recovered in the course of six weeks.

Tenth Attack.—This commenced in the autumn of the same year. The exciting cause was the marriage party of a friend, and the symptoms first showed themselves at a crowded railway station, where he began declaiming from the window of a carriage, after the manner of a political orator. Recovered after two weeks' asylum treatment.

Eleventh Attack.—This attack came on in November, 1887. After passing through the usual phases of excitement was convalescent in seven weeks and sent out on probation. Was more violent and unmanageable than usual during this seizure.

Twelfth Attack.—In May, 1888, was again admitted, suffering from an attack of the usual character. Recovered in six weeks.

Thirteenth Attack.—Came on in October, 1888, and he was received as a voluntary patient. Attack the same as usual. Recovered in three weeks.

Fourteenth Attack.—In December, 1888, was again admitted, and, after the usual period of wild excitement, was sent home on probation at the end of seven weeks.

Fifteenth Attack.—Admitted from probation in May, 1889. Convalescent in one month, and again sent out on probation.

Sixteenth Attack.—In July, 1889, again admitted from probation. Passed through a fortnight of acute mania, and was sent out on probation at the end of one month.

Seventeenth Attack.—Relapsed in September, 1889, and was admitted from probation. Attack rather worse than usual. After two months was again sent out on probation.

Eighteenth Attack.—This came on in May, 1891. As on former occasions, was wildly excited, could not answer questions, raved and gesticulated for days and nights on end. Was discharged as recovered after two months' residence.

Nineteenth Attack.—Came as a voluntary patient in January, 1892, and after a short period of acute excitement was discharged in five weeks.

Twentieth Attack.—The last attack came on in January, 1893. It was similar to those preceding it, and after one month's residence he was discharged as recovered.

Remarks.—Mr. A. B. has continued well since January, 1893, and at the present time (June, 1896) he is in the very best of health, both mentally and physically. He appears to have been at all times a man of an exalted, visionary frame of mind, a superficial reader of abstruse and out-of-the-way books, on the subjects of which he delights to dogmatise, without having any real grasp of them. He is extremely introspective, and likes to analyse the mental condition of himself and those around him. He states that when the attacks came on him he felt very happy and hilarious, with quite a plethora of ideas. He felt as if acting a part, and at the end of an attack remembered everything. He felt as if he had been playing the fool, yet had no feeling of depression in the ordinary sense.

Shortly after the last attack, having been advised that a more active life out of doors would, perhaps, tend to diminish the frequency of his attacks, he purchased a bicycle, and since that time he has been a most enthusiastic cyclist. He sends me the following description of his condition at the present time :—

I am as keen on cycling as ever, and am fully convinced that to it, and it alone, I owe the great improvement that has taken place in my health. I do not remember ever having felt better, or been in better spirits than I am at present, and I give cycling the credit for it. The course and circumstances of my life and conduct have, with the one exception of my indulgence in cycling, in no way altered from what they were before and during the time I had my repeated attacks of illness. You had ample opportunity of judging my condition years before I took to cycling, and the fact that I have enjoyed such excellent mental and bodily health since I took to the pastime goes far, I think, to show you that cycling is entitled to much, if not all, the credit.

I may add, by the way, that I am not conscious of having experienced any ill effects, even though the bulk of the 6,800 miles I have ridden has been on a solid-tyred machine. With this machine I often do forty miles on an afternoon, and feel quite fresh and active next morning. In fact, the whole of my experience of cycling has been of the most pleasant and enjoyable kind, and I do not anticipate it will soon be otherwise.

I can unhesitatingly corroborate Mr. A. B.'s statements regarding the present state of his health, though he seems to be stating the case for cycling rather too strongly. Physically he is most robust—a man of 54, he looks barely 45—and he appears to be more stable mentally than he has been at any time during the seven years I have known him. It does not seem improbable, therefore, that this new hobby has taken the place of the morbid recreations of former years, and so removed one of the most potent exciting causes of his attacks.

OCCASIONAL NOTES OF THE QUARTER.

The Annual Meeting.

The fifty-fifth Annual Meeting of the Medico-Psychological Association, held in London on July 23rd and 24th, under the presidency of Dr. Mickle, was fully occupied with the business and scientific work provided. Indeed, time did not permit of the completion of all that was intended.

The Presidential Address, which was only delivered in part, is now presented in full; and we congratulate Dr. Mickle on fulfilling the expectations which his honourable position in the world of medicine induced us to form. His careful survey of a field which is of the deepest interest to psychologists, his elucidation of difficult medico-legal questions, and his balanced appreciation of a long series of clinical facts all command our respectful attention. Dr. Mickle has given us of his best, the garnered sheaves of an abundant harvest.

Dr. W. F. Robertson showed a series of microscopical preparations, which again gave ample proof of his skill and patience in elucidating the facts of pathology. Other papers of deep interest were read, and the results of research and reflection were unsparingly communicated, and submitted

for the criticism of the meeting. The Association was also favoured with an original paper by Dr. Channing, whose presence as representative of the United States was duly appreciated. His opinions as to the significance of narrow palates are opposed to current teaching, but are supported by a long series of patient investigations. We are, unfortunately, unable to print Dr. Channing's paper in this number of the Journal; but expect to present it to our readers in the January issue. We have also retained reports on the administration of thyroid extract, by Dr. Legge and Dr. Hay, in the meantime.

We can only regret that the attendance was so inadequate. The number of those present, as entered on the book provided for that purpose, was very limited. This is not as it should be, with a membership of five hundred and nine. It cannot be averred that the junior members of the Association are crowded out because there is no room, or because the great majority of Medical Superintendents have left them no choice. They are, indeed, heartily welcome, and should bear in mind that it is to them that the future of the Association belongs. The Medico-Psychological Association has done good work in the past; it has been carried to its present position of influence and strength by the efforts of the men Dr. Outtersen Wood has so timeously commemorated, and those whose active services we yet command; it is for those who have yet to bear the burden and heat of the day to proffer their services, to maintain what has been gained, and to press forward in hope of new victories for science and for humanity.

The Council, too, has its plain duty. The trust committed to them is not fulfilled unless they consider well how they may direct the affairs of the Association so that the attendance at important meetings may be improved, and the effective strength of the members may be directed to conserve and augment the interests at stake. The Association has resolved that the Council shall, year by year, give some account of their proceedings, of the condition of the affairs of the Society; they have been called upon, in fact, to justify their existence. It is hoped that they will respond with some effect to this demand for their *raison d'être*. At the risk of becoming didactic, than which nothing can be more hopelessly out of fashion, we hint that there is a more excellent way. Dr. Savage boldly professes *dissatisfied science* as preferable to *self-satisfied science*. Therein is hope. Truly "the best is yet to be."

Retirement of Dr. Beach.

"There are mile-stones on the Dover road." We have passed one of our mile-stones when we mark where Dr. Fletcher Beach drops out of our official ranks. Fortunately, we do not say good-bye, for we are assured of his good company and kindly aid in the ranks, while he continues to occupy a position of greater freedom and lesser responsibility. Dr. Beach has given ungrudgingly of his time and talents to the Association that placed him in the responsible and honourable post of General Secretary. Generous and well-deserved acknowledgment of his services was made at the Annual Meeting, where he occupied his place for the last time. The Association is fortunate in having secured Dr. Percy Smith as his successor, and we trust that it will be long before we have to chronicle another change in this important office.

Criminal Responsibility.

The Report of the Criminal Responsibility Committee has now been finally adjusted, and the compromise effected between extreme views may be accepted as the best possible at the present time. While the legal mind is unbending from rigid formalities of doubtful authority, the medical attitude should be one of expectant attention. We are not in a position to dogmatise; our information is not exact, full, and precise in leading to inevitable conclusions. Having plainly indicated that the McNaghten case does not now meet the necessities of justice, we leave it to legislators to amend the practice of the courts when that can be done. The advance of medical science has discredited the answers of the judges as they were formerly interpreted; but a constructive policy does not at present appear to be possible. Time will infiltrate the courts with modern ideas, and the stability of jurisprudence, as administered by able men of whom the nation is justly proud, is wisely resistive of immature proposals.

The Association has been well served in this matter by the Committee appointed two years ago. The exhaustive memorandum prepared by Dr. Orange, and the vast amount of labour bestowed upon the investigation necessary by Dr. Mercier must be gratefully acknowledged. At the same time, there is in the Report no expression of finality; it does

not discourage further research and future consideration of the problems involved. On the contrary, it is a settlement *ad interim*; and we again remind those whose duty leads them into the witness-box that all important cases should be recorded with precision and promptitude.

Pensions and Gratuities.

During the past year the question of pensions and gratuities to those engaged in asylum service has been repeatedly before the Association. We direct special attention to the communication we have received from Dr. Murray Lindsay which will be found under "Notes and News." We would regret to learn that Dr. Lindsay contemplates retiring from the position he has so long held to the advantage of the county of Derby, were it not that we are assured that he will be no less active in promoting the interests of the Association in his well-earned leisure. As the questions at issue are still *sub judice* we refrain from going into details at present. It is, however, encouraging to learn that the English and Scottish Commissioners are in full sympathy with the demand that asylum officials should be properly provided for by pensions and gratuities in the circumstances so repeatedly made clear.

British Medical Association.

The meeting of the British Medical Association at Carlisle, held in the end of July, attracted many visitors to that historic town. The section of psychology was most ably and hospitably presided over by Dr. J. A. Campbell, who was supported by a fairly good attendance. The meeting will be memorable by reason of the great pains taken to render it successful, and the interesting nature of the scientific work presented. We must regret that the section was not so fully attended as it deserved. No doubt it was difficult for those specially interested in psychology to be present for two successive weeks at places so distant as London and Carlisle. We have remarked already upon this difficulty, and must further add that at Carlisle there was an additional cause for regret in failure to present communications promised. This is a growing evil, and must be remedied. One discussion at Carlisle would have fallen

through altogether had it not been that the President proved equal to the occasion, and stepped into the imminent deadly breach. We doubt if it is entirely respectful, it certainly is unfair, to a President to require him to act as stop-gap. However, Dr. Campbell proved capable and ready to meet the difficulty, and his extempore speech needed no apology. His Presidential Address was full of interest. Instead of attempting to survey man from China to Peru, he wisely limited the scope of his remarks to the district where he has done such admirable work for the insane.

Private Care.

The section of psychology rarely lets an opportunity slip of crystallising opinion in the form of a resolution. This year Dr. Rayner moved for what would be a distinct improvement in the Lunacy Law of England. We commend the resolution in that it promotes the medical treatment of a class of cases at present productive of considerable difficulties. The provision for the temporary care of incipient and non-confirmed insanity which has proved so valuable in Scotland, should be pressed upon the attention of the Government at the proper time. Meanwhile the matter has been referred to the Parliamentary Bills Committee of the British Medical Association.

The Woodilee Asylum.

We regret to have inserted an inaccurate paragraph referring to an action, brought by the Barony Parish of Glasgow, against the General Board of Commissioners in Lunacy regarding the position of this Asylum, in the last number of the Journal (page 684). The Barony Parish Council contended that the asylum was a Public Asylum, or if not a Public Asylum that it was a Parochial Asylum, and that in either case it did not require a license from the General Board. The Parish Council further maintained that if such a license was required, the General Board were not entitled as a condition of granting the license to enforce Rules, prescribing among other things the number of the Managing Committee, and insisting that the Committee shall act independently of the instructions of the Council. This action was decided by Lord Low on the 11th January, 1896,

and on every point he decided against the Parish Council. In the course of the debate the question arose whether the Rules which had, in accordance with their powers, been framed by the General Board and had received the approval of the Secretary of State, had been laid before Parliament as the statute required. This question not having been formally raised in the "summons," Lord Low did not then deal with it; but on the General Board and the Parish Council agreeing to the "summons" being amended so as to bring the matter formally before him he appointed 7th March last for the resumed consideration. The result of the resumed consideration (not the "appeal" as it was erroneously called in our paragraph) was that Lord Low decided that the Rules had not been submitted to both Houses of Parliament as required by statute. In this contention, therefore, the Parish Council were successful. We understand that the omission to submit the Rules to Parliament has now been repaired. They were revised by the General Board, who made some amendments upon them, among others one requiring the Managing Committee to submit their minutes for approval to the Parish Council. They then received the sanction of the Secretary for Scotland, and were duly submitted to both Houses of Parliament before the end of last Session.

PART II.—PSYCHOLOGICAL RETROSPECT.

AMERICAN.

By Fletcher Beach, M.B., F.R.C.P.

American Journal of Insanity, April and July, 1895; *Alienist and Neurologist*, July, 1895; *The Journal of Nervous and Mental Disease*, June, 1895.

Dr. Clara Barrus writes in the *American Journal of Insanity* an article on "Gynæcological Disorders and their relation to Insanity." She tabulates one hundred cases in which examinations were made whether the patient presented symptoms calling for uterine examination or not, and is of opinion that a thorough physical examination is necessary in all female cases, since the manifestations which would lead to examination were only noted in three patients. Very often the pain and discomfort felt by insane patients is misconstrued, and so, while we get no expression of pain itself, we may find the patient suffering from delusions that she is pregnant, that she has been violated during the night,

and so on. A synopsis of the table is given, and shows the age of the patient, whether married or not, the presence or absence of menses, leucorrhœa or masturbation, of anomalies and new growths, the condition of the uterus and external genitalia, and the kind of mental disease which is presented. The gynæcologist who learns that it is the exception rather than the rule to find an insane woman with normal pelvic organs must be careful not to assign these abnormal conditions as a cause of insanity, but to keep an open mind, suspending his conclusions until further data can be examined. No doubt the causes of insanity in women are as varied and many of them are identical with the causes of insanity in men, but women have an additional physical and mental strain resulting from the crises which they have to undergo, such as the establishment of puberty, the monthly period, pregnancy, the puerperal state, and the climacteric. None of these by itself is sufficient to produce insanity, and when any of these experiences are said to be the cause of mental disease, we must acknowledge that though these may be the exciting cause, yet the predisposing one is an unstable organisation, causing the patient to be disturbed by occurrences which would only temporarily upset a healthy organism. As regards the table itself, one must guard against the erroneous opinion that the lesions which present themselves are associated more frequently with certain forms of insanity than with others, for although there were thirty-six cases of melancholia and twenty-one of dementia, and only nineteen of mania, ten of paranoia, and twenty-four of miscellaneous mental disorders, we must remember that cases of melancholia and dementia are more tractable and more easily examined, while those of acute mania, paranoia and sexual perversion are examined with difficulty. The author concludes that each case on admission should be examined, and if there is any abnormality present it should be removed if possible ; by this means the degree of nerve irritation will be lessened and one of the " stumbling blocks " in the way of the patient's recovery will be removed.

Dr. Percy Wade gives his experience on " Chlorobrom as a Hypnotic in the Insane." This drug is a mixture of equal parts of bromide of potassium and chloralamid dissolved in water, and was first introduced to the medical profession by Professor Charteris of Glasgow. The solution was first used by him for the prevention and alleviation of sea-sickness, for which it is said to be an excellent remedy owing to its hypnotic action ; acting upon this latter suggestion Dr. Keay employed the drug in the treatment of mental disease. It does not depress the circulation and the heart so much as the bromides, sulphonal or other allied drugs, and is less disagreeable to take than paraldehyde, which has an objectionable odour and is often followed by lassitude, sickness, and headache in the morning. Chlorobrom is not disagreeable to take, leaves no after ill effects, and causes no derangement of the

stomach or bowels. The drug was administered by Dr. Wade ninety-six times to sixteen patients, including three cases of acute mania, three of melancholia, seven of dementia, and one each of active melancholia, epilepsy, and periodic mania. As a rule, the dose was an ounce and was found sufficient to produce sleep in most cases. It was found very useful in simple melancholia, but failed to act in acute melancholia. In acute mania it was found to quiet and produce sleep, although taking longer to act, the sleep being as refreshing as that produced by other hypnotics. In seven cases of dementia the drug did not produce the required result in a single case, but in one of insomnia after epilepsy the action was very favourable.

Dr. James Burton describes "The Blood in the Insane." In this paper the condition of the blood in several forms of insanity is pointed out, with particular reference to the leucocytes as seen in specimens stained with Ehrlich's triple stain. The "heat" method was used in fixing the blood on the cover glasses at a temperature of 120° C., the staining and mounting being carried out in the usual way. In some cases, as a means of comparison, Dr. Gowers' instruments were used in estimating the hæmoglobin and number of red and white discs. The cases consisted of three of senile dementia, four of general paralysis, one of Graves' disease, one of chronic mania, one of katatonia, one of acute mania, two of stuporous melancholia, and one of acute melancholia. The history of the fourteen cases is given and the result of the examination of the blood in each case. The author noticed that in the cases of senile dementia there was, as a rule, increase in leucocytes; while in cases of general paralysis, with one exception, they were markedly decreased; and that in cases with a tendency to maniacal excitement the number of leucocytes was greatly decreased. Some coloured illustrations, showing the condition of the blood in four cases, add to the interest of the paper.

Mr. W. P. Gerhard, C.E., at the request of Dr. Henry Hurd, the Secretary of the American Medico-Psychological Association, gives a description of the "Rain-Bath" as employed in public institutions. The rain-bath, particularly as a form of public bath, had its origin in Germany, one of its chief advocates being Dr. Oscar Lassar. In the United States it was brought to the notice of the engineering profession by descriptions in the *Engineering Record* as far back as 1875, but it was not until 1889 that rain-baths attracted more general attention, the first one being installed at the suggestion of Dr. Baruch at the New York City Juvenile Asylum. In August, 1894, the first large bath-house fitted up entirely with rain-baths was completed at the Utica State Hospital. The novel feature of construction in this bath is the inclination at which the overhead douche is placed, the object being to avoid a vertical stream from the douche striking the head of the bather. The lukewarm water strikes the body from the

neck downward and the head is not wetted, unless the bather purposely places the same under the shower. Mr. Gerhard enumerates eight reasons why the rain-bath should be used, one of them being that its stimulating and invigorating influence is much higher than that of a bath taken from a tub. An illustrated description is then given of the new bath-house at the Utica State Hospital, at which rain-baths are in operation, and we learn that the bath-room is fitted up with thirty overhead nickel-plated brass douches which run at the rate of $2\frac{1}{2}$ gallons per minute. Besides these there are nine hand sprays which are used for patients who need the assistance of attendants in bathing. An ingenious form of hot-water apparatus, called a "Gegenstrom Apparat," which is extensively used in Germany, was used to heat the water, and it does so instantaneously, uniformly, and without noise. The water is not heated above 110° F., and the water and steam valves are so placed that it is impossible to turn on the steam without first turning on the water.

"Bright's Disease and Insanity" is the title of a paper by Dr. Bondurant. For the last four years a large amount of work bearing on the question of the relationship between nephritis and insanity has been done at the Alabama Insane Hospital. About 1,700 cases of insanity have been subjected to at least one careful physical examination and analysis of the urine; while the cases that exhibited bodily disease of any importance, renal or otherwise, were followed with care, and repeated examinations of the urinary secretion were made. The renal lesions found post-mortem have been studied by the microscope in about 200 cases. It was found that albumen, together with renal casts, could be detected in more than half the cases of chronic insanity treated in the asylum, and in the urine of 75 per cent. of the cases recently admitted; that a large proportion of those whose renal secretion is abnormal exhibit at some time or other evidence of renal disorder; that 25 per cent. of the patients whose urine contains tube casts and albumen present such clinical evidence of nephritis as would enable a practitioner to make the diagnosis of the disease without examining the urine; and that 75 per cent. of the kidneys examined post-mortem showed pathological changes. The author draws the conclusion from these facts that many of the patients in whom insanity and nephritis co-exist are insane in consequence of the nephritis. This opinion has been objected to by physicians attached to other hospitals for the insane, and the author is of opinion that the reason for this is that these gentlemen fail to find them, *i.e.*, casts and albumen, where they do exist, rather a bold assumption one would think for the Assistant-Superintendent of an Insane Hospital to make. Dr. Bondurant then discusses the question whether Bright's disease does or does not cause insanity, and supports his opinion that uræmia not only produces transient mental symptoms, but true insanity,

by quoting the opinion of other authors who have written on the subject.

Dr. Peterson writes a paper full of facts entitled "Cranimetry and Cephalometry in relation to Idiocy and Imbecility." He refers to a former paper in which a brief description was given of the instruments needed, the methods employed, and the facts to be gained by a study of the conformation of the head and skull in criminals and the insane, and says that as in idiocy, and particularly imbecility, remarkable deviations from the normal type of head and skull are met with, he thinks more attention should be paid to a study of cranimetry in this class of cases than has hitherto been the case. The facts related in the paper are given as a guide to the study of the kind of disease under consideration. The common or well known cranial deformities are platicephalus or flat-headedness; leptocephalus or narrow-headedness; macrocephalus or large-headedness; microcephalus or small-headedness; oxycephalus or steeple-shaped head; scaphocephalus or keel-shaped head; and plagiocephalus or oblique deformity of the head. The two systems of measurement—the craniometrical and cephalometrical—differ only slightly from each other, but the former is the more exact since every portion of the naked skull is attainable. The author passes over the long series of craniometrical measurements and the thirty-eight cephalometrical measurements recommended by Benedikt and selects only those which are absolutely necessary to form a just idea of the capacity and symmetry of the head. The measurements he recommends are eleven in number, viz., 1, the circumference; 2, the naso-occipital arc; 3, the naso-bregmatic arc; 4, the bregmato-lambdoid arc; 5, the binauricular arc; 6, the antero-posterior diameter; 7, the greatest transverse diameter; 8, the binauricular diameter; 9, the two auriculo-bregmatic radii; 10, the facial length; 11, the empirical greatest height. In addition to acquiring these mathematical data, cephaloscopic drawings are invaluable as exhibiting deformity clearly to the eye; hence the horizontal circumference, naso-occipital curve and binauricular curve should be taken with a strip of lead or a conformateur, while the mathematical data are obtained by a pair of calipers and a tape measure. Six per cent must be deducted from the measurements of the circumference, the naso-occipital arc, and the binauricular arc to allow for the scalp and hair. The author has prepared two tables containing the measurements just noted, one consisting of the measurements of normal heads, the other those of eleven adult male and eight adult female paralytic imbeciles. On examining these he comes to the conclusion that in all the cases the skull is more or less diminished in size on the side opposite to the paralysis; that there is a pronounced tendency to diminution in all dimensions and capacity; and that while all of the heads are below the normal averages, more than 75 per cent. are

below the lowest limit of physiological variation in some of their dimensions. The paper is interesting, but the author omits to mention the work of Shuttleworth in the same direction, besides which it is necessary to add that outlines of heads have in many cases been made and measurements of the circumferential, transverse, and antero-posterior diameters, both by tape and caliper measure, have been taken in every case admitted into some of the asylums for idiots in England for many years past.

Dr. Martin W. Barr writes an interesting paper on "Moral Paranoia" in the *Alienist and Neurologist*. The author gives a definition of the word paranoia and the authors who have used it, most of whom have been of German origin. There are two classes of paranoia, the mental and the moral; in the former the intellect is dominated by one or a set of fixed ideas and delusions, and gradually weakens and degenerates, and the ethical sense is not necessarily implicated; in the latter, the ethical sense is either weak or wanting, and it may or may not be associated with intellectual deficiency, but often there is intellectual precocity. This moral form of paranoia is better known in England under the name of moral imbecility. Moral paranoia is divided into two kinds; in the first, the moral sense has not been developed, or through accident or disease has been arrested, but it is capable of development through training; this class is comprised of people not wilfully bad, but of weak wills, easily led astray, and whose weakness of will develops and grows with their physical growth until they astound society with some sudden outbreak. There are many at present under training in various institutions in England and America, in which they become useful members of society, and as they are totally irresponsible they should always be under restraint, so that they may not become vagrants or criminals or the tools of wicked men. In the second class, owing to degenerative tendencies and practices through successive generations or through the taint of some remote ancestor, the moral sense is absolutely wanting. In this type the intellectual faculties may be found defective, but more frequently are unnaturally developed, so that a person of this sort is dangerous to himself and his fellow citizens. The worst class of criminals, the murderer and the harlot, are examples of this type. Patients of this class are in this condition from birth, and even as children are self-willed, obstinate, and delight in sulking, in annoying children, and in torturing animals. According to Lombroso, physical anomalies, such as cranial and facial asymmetry, premature synostosis, unusual frequency of left-handedness, large orbits, prominent zygoma, nervous contraction of face, and a cold, glassy immobile look are found in this class. The line that separates these patients from criminals proper is distinct and has long been recognised by alienists, but unfortunately the lawyers do not appreciate the nature of delusional diseases, nor the frequency of

instances in which men not only lose all sense of responsibility, but are regardless of harm to themselves. Children of this class should be placed in special schools adapted to their needs in order that a firm and well directed discipline may enable them to attain some degree of self-helpfulness, and the State may be spared the ignominy and cost of criminal trials and punishments. They should be detained for life, and as it has been found they can be trained, this treatment should be put in practice, so that their lives may be made happy and useful and they may become docile and harmless. Education does the greatest harm as it fosters the ill we would cure; in teaching them to write, we give them increased power of mischief, and therefore instruction should be given only in physical work. To prevent moral imbecility is a larger question still; the public require to be educated and informed that the intermarriage of persons tainted by insanity must be prevented, and that during the period of pregnancy great care should be taken to keep the future mother in a tranquil condition. The author is of opinion that castration should be adopted in cases of this kind, and mentions that the late Dr. Kerlin before his death strongly advocated it.

Dr. Barr is also the author of a paper on "The Influence of Heredity on Idiocy" in the *Journal of Nervous and Mental Disease*. He commences by quoting the opinions of various writers on heredity who all agree that peculiarities and abnormalities are apt to recur in descendants for many generations. The reason why only one in a family may be insane or idiotic, showing that the taint is concentrated, may be partly due to surrounding conditions and the temperament of the parents at the time of conception, and partly to prenatal influences acting on the child during the mother's pregnancy. Moreau of Tours pointed out that neuroses are interchangeable in transmission from generation to generation, and on examination we find that there are two laws at work; the first is a reversion to the original healthy and perfect type, so that the taint becomes less noticeable and after many generations is not found at all; the second causes the taint to become more pronounced, and a simple nervous disease may appear in successive generations in the form of a pronounced neurosis. After references to the work on the subject done by English authors, Dr. Barr refers to the results of the Commission appointed by the Legislature of Connecticut to investigate the cause of idiocy. The Commission reported that out of 164 cases, heredity was undoubtedly the cause in 70; this is much the same percentage as was found in the census of 1873, taken at Berne, when 55 per cent. of the idiots were noticed to come from neurotic families, and Dahl, of Norway, came to the same conclusion. Dr. Barr gives four genealogical tables, one by Dunlop, one by the author of this retrospect, and two by himself, which show how the predisposition to idiocy can be traced through three or four

generations. Consanguinity, the author finds, is not a common cause, and this agrees with the opinion of the English and French authors who have examined into the subject, although idiocy no doubt frequently appears where intermarriage has been frequent. An appalling example is that of the family known as "The Tribe of Ishmael," whose history traced through a period of forty years shows that from one neurotic man descended by consanguineous marriages two hundred and fifty families, numbering altogether five thousand individuals whose continuous criminal record has poured out a flood of imbecility and crime.

"Merycismus or Rumination, with a report of two cases," is the title of a paper by Dr. Riesman in the same journal. The first author to mention this disease was the great Italian anatomist, Frabicius ab Aquapendente, the teacher of William Harvey, who lived at Padua towards the close of the sixteenth and the commencement of the seventeenth century. The literature since then has been carefully reviewed by Johannessen and Singer, who both wrote monographs on rumination and to which those who are interested in the subject can refer for a very extended bibliography. Rumination is defined "as a periodic regurgitation of the food unattended by nausea, retching, or disgust, the regurgitated material being either voluntarily ejected from the mouth or again swallowed, remastication not being an essential part of the act." This regurgitation is analogous to the process of rumination in the lower animals, and the factors which cause this process are two—a lessening of the intra-thoracic pressure and an aspiration of the gastric contents. The stomach itself is passive, as Majendie proved in his famous experiment on vomiting, but writers are not in agreement as to whether abdominal pressure is necessary or not. Rumination is a reflex act and is presided over by a centre in the medulla oblongata, but though the mode of its production has been fully explained we are as yet ignorant of its cause. Pathological anatomy throws no light on the subject, for although Arnold and Luschka found in their respective cases dilatation of the lower end of the œsophagus and an unusual thickness of the internal branch of the spinal accessory nerve, yet the same condition has been noted in cases that did not present rumination during life, while in other cases the œsophagus was normal, and with respect to the hypertrophy of the nerve, its size is known to vary under normal conditions. The condition therefore must be looked upon for the present as a functional disorder of the stomach, and considered as a motor neurosis. The neurotic constitution is an important element in its causation, and a German physician, Nücke, who suffered from the affection, is of opinion that it is closely related to neurasthenia, for when his nervous system was most unstable, the rumination was most energetic. The disease is more common in males than females, and as a rule causes no serious disturbance unless the patient continually brings up the

regurgitated food. The treatment is very unsatisfactory and very few cases of cure have been recorded. Carminatives, electricity, and nerve sedatives have been employed, but with only temporary results. In one case, however, in which hyperacidity of the gastric juice existed, treatment of this condition permanently stopped the disorder.

GENERAL.

By J. F. G. Pietersen, M.R.C.S.

Epilepsy.

Reference to Flechsig's Bromo-opiate Treatment of Epilepsy was made in the last number of this Journal. Though the results chronicled have so far been few in number, the adoption of this form of treatment in severe or obstinate cases of epilepsy, especially when associated with pronounced mental disturbance, appears worthy of consideration. In the *Zeitschrift f. Psychiatrie*, Bd. lii., two communications have appeared, each of which gives most favourable results. Linke has administered opium and bromides in succession to seven epileptics, six males and one female, in all of whom marked psychical aberration existed. In rapidly increasing doses he exhibited opium first for six weeks, suddenly changing the medicament to large doses (7.5 grms.) of bromide, which being continued for another period of six weeks was then reduced to a daily dose of 5 grms. This is the method advocated by Flechsig, though other therapeutists have lengthened the periods of administration of each drug. Linke found that during the opium course the epileptic seizures increased greatly in number, and that the body weight in some cases showed a marked diminution. As soon as the bromides were substituted for the opium the fits immediately diminished in frequency, and the body weight in the affected cases increased again. The ultimate result of the treatment was that in one patient the seizures had not recurred from the commencement of the bromide course until the date of his paper; in another, one fit occurred on the third day after beginning the bromides, and then after an interval of freedom for nine weeks two seizures ensued; a third patient had a fit on the first morning of the bromide treatment, after which an interval of sixty-five days without fits elapsed, when the bromide had to be discontinued owing to bromism; five days after its withdrawal the patient had another fit. With reference to the mental condition two patients showed a comparative improvement, they became more cheerful and patient of control; one of these, who had been subject to accessions of intense furor, subsequently remained quite free from them. Two of his seven patients died during treatment, one apparently by reason of deleterious action of opium on an affected cardiac

muscle, the other owing to exhaustion due to the epileptic status. In nearly all a moderate degree of constipation was induced when the daily doses of opium reached .60 grms., easily overcome, however, by simple aperients. When the maximum dose of opium was reached serious symptoms supervened, which rendered careful observation of each case needful. As only two and a half months had elapsed between the commencement of the bromide course and the publication of his paper, Linke discreetly draws attention only to the remarkable effects of this mode of treatment in cases hitherto wholly uninfluenced by therapeutic measures; he certainly makes no claim for the method as a specific curative.

In the same journal Rabbas relates his experience of a similar course of treatment adopted in eleven female and five male epileptics, and his communication has greater value as two years have elapsed since the experiments were made. Fifteen of these cases had previously been unsuccessfully treated with bromides only. Rabbas began with .3 grms. of Pulv. Opii per day, increased this gradually to .9 grms., after which he suddenly changed the treatment to a bromide course of 7.5 grms. daily. During the opium treatment the number of fits increased; in one case only did the body weight remain stationary, in every other instance observed there was some diminution. In six nausea and vomiting occurred, but constipation was not a marked symptom. Some mental improvement was noted in every case. With the sudden cessation of opium severe vomiting sometimes ensued, but dangerous symptoms never actually showed themselves. As soon as the bromides were given in place of the opium the fits at once diminished in frequency, in twelve patients they disappeared, and in one case only was there a more serious renewal of the fits. In five cases the attacks remained absent from six to ten months, and on recurrence were less frequent than formerly; in three there has for two years been no recurrence whatever. Two of his cases died during treatment, both (females) succumbing to the exhaustion of the epileptic status towards the end of the opium stage. The results among the males were less satisfactory than among the nine surviving females.

The treatment is one that may certainly be attempted in cases of some severity, though great care must necessarily be exercised in their supervision during the high dosage of opium and in the transition period of medication.

Voisin and Petit (*Arch. de Neurologie*, 1895, April-August) show that in many cases of epilepsy the attacks occur or recur in groups, while the intervals are marked by partial or complete absence of single fits, and that towards the end of such an interval it may be noted that symptoms indicative of gastro-intestinal disturbance appear, such as a thickly furred tongue, constipation, epigastric distension, anorexia, etc. One or two days after the onset of these signs of digestive abnormality the epileptic phenomena make their

appearance—mental symptoms and actual epileptic fits or their equivalents. As soon as these latter, the recurrences of which are very numerous within a short period, have spent themselves, the condition of the tongue will be found to have improved, the other digestive disturbances will pass away, the whole alimentary function in fact assuming a normality of course, until the supervention of another similar functional gastro-intestinal disturbance, apparently without any definite cause, ushers in a new series of epileptic onsets. In patients prone to well-marked psychical epileptic phases, either peri- or post-epileptic, the furred tongue, constipation, etc., may be observed to be almost constant antecedent symptoms, and with a return to quietude these alimentary disturbances will be found to disappear. In a case in which the series of seizures lasting from six to eight days was interrupted by a few days' cessation of fits it could with certainty be demonstrated that some causal connection existed between the two series of phenomena. Massalongo some fifteen years ago described such cases as instances of "gastric epilepsy," and Pommay (*Rev. de Médecin*, p. 449) has cited two examples of his own and one of Lépine's as illustrative examples of this condition. He attributed the cerebral disturbance to reflex irritation along the vagus, but Voisin and Petit follow Massalongo in regarding them as due to an auto-intoxication. As among uræmic symptoms epileptiform onsets may occur with difficulty differentiable from true epileptic fits, we have an example at hand in support of their theory, and a causal connection is very probable when we consider the close association of the digestive abnormalities with the periodical recurrences of fits, the more so when we remember that the former are invariably antecedent phenomena. The digestive disturbance may be either the cause or the consequence of an auto-intoxication, and probably the latter, for we are frequently able to recognise the occurrence of some alimentary disturbance after a known intoxication, and always if the intoxication is the result of some ptomain, and the likeness of this to the ante-epileptic alimentative disturbance is striking. The authors have on this basis made a laborious investigation in which successive analyses of the urine for albumen, tests of its toxicity, etc., were made, and careful quantitative estimation of its urea, phosphates, etc., undertaken. In such urine analyses of epileptics they appear to have found, directly after the fit-periods, a substance with a peculiar musk-like odour, soluble in water, and of extreme toxicity towards lower animals. Its subcutaneous injection caused death with convulsions. From these examinations they conclude that antecedent to the epileptic accessions the urine has been hypotoxic, and after the fits hypertoxic. The condition of the arterial system was also closely investigated during and after the attacks. Sphygmographic tracings showed that the blood pressure during the tonic and clonic phases of a fit fell so rapidly that a superficial wound inflicted during a fall ceased to bleed; invariably after the stertorous respirations of the second

stage of a fit the blood pressure rose, and any wound incurred began to bleed again profusely. Careful note, too, was taken of the general sensorial, speech and motor functions, and special attention was paid to the condition and functions of the alimentary system. Heredity, alcoholism in the young, drug-abuse, and various chronic affections, *e.g.*, syphilis, were found to be predisposing influential factors towards such auto-intoxication. The blood was carefully examined, and in some instances micrococci were discovered, but the authors wisely do not attach much importance to such discovery, though they think their presence may indicate that toxine formation is being carried on within the body. Without going further into their investigations we may note that they express the conviction that epilepsy, not only the gastric but also other idiopathic forms, may be regarded as the result of an auto-intoxication, the poison acquired or collected in the organism inducing these convulsive phenomena. The possibility that some other operative cause may be existent, as in the production of Jacksonian and reflex epilepsy, is not lost sight of, but they consider generally that—1. A hereditary predisposition exists in the central nervous system for the production of epileptic onsets. 2. That the epilepsy may result either from some reflex nervous disturbance or from an auto-intoxication, and that this may be caused by an auto- or hetero-infection. They close an interesting paper by urging the importance of close attention to alimentation, the use of purgatives, intestinal antiseptic medication, diuretics, etc., in all cases of epilepsy, indicating how, under certain circumstances, these measures may have a favourable influence in warding off or diminishing attacks.

Sulphonal.

The Pathogenesis of Hæmatoporphyrinuria.

In the *Zeitschrift f. Klin. Medicin* (Bd. 28), Prof. Stokvis makes a contribution to our knowledge of the ætiology of this affection. The continuous administration during successive days of a known quantity of sulphonal to dogs and rabbits was found to cause the appearance of hæmatoporphyrin, which, though in most instances of small amount, was demonstrable, as the majority of the urines examined were free from albumen. It was only when the drug was pushed to a fatal termination that albumen appeared during the last days of life. Examined post-mortem, the gastric mucous membranes of the subjects experimented upon were found to be studded with large and small hæmorrhagic punctæ, and spectroscopic examination displayed the presence of hæmatoporphyrin in these localities. A similar abnormal condition of the urine was produced by the introduction of pure blood into the stomach. Small quantities of blood were daily administered to dogs and rabbits, with the result that hæmatoporphyrin speedily appeared in the urine. The same effect has been produced by Zeehuisen by feeding animals with raw (or hæmoglobin containing) beef.

The artificial digestion of blood with pepsin, hydrochloric acid, and sulphonal results in the formation of hæmatoporphyrin. An interesting question was raised as to whether this abnormal urinary constituent, in cases of lead colic, could in a similar manner be explained, and experiments on rabbits rapidly poisoned with acetate of lead, after some days' fasting, proved the conjecture to be correct. Numerous mucous hæmorrhages in the stomach were found, and spectroscopic examination of these revealed the presence of hæmatoporphyrin. The ætiology of this symptom would therefore appear to be a transformation of hæmoglobin in the intestinal tract through the action of the digestive fluids; an explanation, too, is furnished of the manner in which sulphonal acts as a poison.

As an addendum to Hirsch's case of acute sulphonal poisoning mentioned in the last number of this Journal, we may note a case published by Wyss (*Correspondenzbl. f. Schw. Aertze*) of a young girl, which, from the description, appears to have been one in which the hypnotic effect of the drug was combined with a state of hysterical lethargy. Sulphonal, it may be noted, rarely acts as an acute poison in the normal healthy subject. Thus Neisser has related the case of a patient who with suicidal intent took no less than 100 grms. of sulphonal in one dose—the only result was a prolonged sleep of four days. In Wyss's case the early symptoms following four doses of 1 grm. of sulphonal were lethargy, succeeded twenty-four hours later by acute muscular contractions (probably hystero-epileptic in character), and later on by alternations of these conditions, lasting altogether for fourteen days. The patient, after complete recovery some months later, denied all recollection of the affection. The danger of sulphonal treatment lies rather in its long-continued use than in any direct acute effect; the urine is evidently never affected in acute poisoning by very large doses.

Trional.

Some cases of chronic trional poisoning have been published by Reinicke (*Deutschr. Med. Wochenschr.*, 1895, No. 13), who instances one in which 40 grms. of trional had been administered during 107 days (in which, however, there were intermission periods of 21 and 8 days). He found the urine to contain free blood, and Quinke doubts whether in trional poisoning hæmatoporphyrinuria ever occurs. Schulze, however, in 1894, described a case in which hæmatoporphyrin certainly occurred in the urine. Reinicke's case, which also had dysenteric symptoms, recovered on ceasing the administration of the drug.

Acetonuria and Mental Disorder.

Prof. Wagner, Dean of the Vienna School of Medicine, in a recent paper read before the Vienna Medical Society on Gastro-intestinal derangements and mental affection, remarks that acute

cerebral disease is not an uncommon sequel of febrile affections, and that a similar relationship exists between infectious diseases and polyneuritis, for the last-named may be caused by toxic agents such as lead, alcohol, etc., as well as by specific infectious maladies, such as pneumonia, enteritis, etc., and by impairment of the gastro-intestinal functions. As infectious diseases are now regarded as due more to the toxins derived from the specific micro-organisms than to the micro-organisms themselves, these causes must also be looked upon as toxic in their nature. In like manner mental disorder may arise as the result of a perverted gastro-intestinal action, and acetonuria is the most noteworthy symptomatic evidence of this. Acetone, though a normal urinary constituent, is increased during increased tissue metabolism. It has been found in the blood in febrile cases by Von. Jaksch, who also first drew attention to its presence in the urine. It appears to originate in large measure during abnormal gastro-intestinal action, and the perverted metabolism which causes it probably leads to the formation of toxins capable of inducing serious mental disturbance. Wagner advocates the use of iodoform in daily doses of 1 grm. divided into ten parts, each of which would therefore contain about 2 grains. Acetonuria, in his opinion, is due either to micro-organisms or fermentative changes in the intestine, and as improvement occurs when excess of acetone is no longer a urinary constituent, he suggests that gastro-intestinal disinfection would probably be the best way of treating these cases.

Aphasia in Linguists.

Pitres (*Rev. de Méd.*, 1895, H. xii.) leads up to the description of a case of aphasia in a linguist by a careful review of the literature of this particular occurrence of speech disturbance. The instances cited from the works of Trousseau, Charcot, Bastian, etc., were of individuals who had been competent linguists in two or more languages, French, and a dialect or patois such as Gascon or Basque, or more widely differentiated languages such as German, English, Spanish, Italian, Russian, etc. In each of the six instances, quoted from standard works, the aphasia was the result of a right hemiplegia, and in every case there was immediate loss of the speech originating faculty and speech recognition. A gradual recovery ensued in every one, but in no case did any of the patients reacquire full comprehension or faculty of speech in more than one language, the others in which they had been able to converse fluently having become mainly unintelligible to them. One patient, born in Béarn, and who up to his twelfth year had never spoken or heard any other language than the dialect of that district, and who later in life acquired a proficient knowledge of pure French, which he then invariably used, became affected at the age of 48 with right hemiplegia and

aphasia. Three years subsequently he could again converse in French, but he had lost all power of speaking his native dialect though able in a certain measure to understand what was said to him in it. The second patient, who spoke Gascon and French before his aphasia, reacquired the latter, and similarly to the first failed to speak the dialect, though understanding it when spoken. In the third case, able to speak French, Basque, and Béarnese, the reversion was to Basque alone. The fourth, a French, Spanish, and Italian linguist, lost his capacity to reacquire the last named language, regaining his native tongue, French, and the Spanish he had learnt to speak when 25 years of age. The fifth case, that of a Frenchman, who was able to converse in four languages, as well as in the Basque dialect, reacquired only his native tongue and lost totally all perception of or power of speech in the others. The sixth case considered was similar to the last described. It appears from a consideration of these similar cases that the mother-tongue, with one exception, was the first to return. Pitres is of opinion that the course of events in the aphasia of polyglottics can conveniently be divided into stages: (1) the total loss of the power of recognition of any language; (2) a regular return of comprehension of that language which had most frequently and readily been used by the patient prior to his affection; (3) a regular return of the faculty of expressive speech in such a language; (4) a return of ability to comprehend a strange language; and (5) the eventual restoration of ability to converse in such. It appears to us that Pitres has lost sight of the fact that in the speech education of the cerebral centre in childhood and even in adult life the right centre may receive in a greater or less degree impressions mainly conveyed to and registered in the left, but that the left alone usually acts as the emissive centre for speech. In speech re-education then, after destruction of the left centre, the right very soon acquires the power of recognition, having probably had some antecedent preparation, but the speech originating faculty is a slower process, as the function has to be worked up to a proper degree of action. As early impressions are the most lasting, the mother tongue will be the one most easily reacquired by the uninjured centre; any other language would probably be difficult of acquirement, in proportion to the previous reception or non-reception by the right centre of speech impressions. Another point is that in all these cases the reacquirement appears to have taken place primarily of that language which was used to the patient on his regaining consciousness—so that it resolves itself into a matter of education of a more or less prepared right speech centre, and in proportion to its state of preparedness, so will recognitive and expressive speech power be more or less rapidly developed. It may be that the right centre has never received any impressions whatever, and in that case the language will be as difficult to acquire as if it had never previously been known. The case related in detail by Pitres was

that of a man aged 35, a competent French, Gascon, Spanish, Italian, English and Arabic linguist, and who after an apoplectic seizure had right hemiplegia with aphasia. The hemiplegia soon disappeared, so that after two months traces only of that affection were left. The aphasia disappeared more gradually. His power of comprehension returned 17 days after the seizure, and was limited to French; he was, however, utterly unable to express himself therein. Three weeks later he was able to understand whatever was said to him in that tongue, and he began to articulate, voluntarily, certain French words. His acquired languages remained completely incomprehensible to him. Three months later he was brought into contact with some of his Gascon relatives and in three days he acquired the recognition of, and in some measure the power of expression in that dialect. The four other languages in which he had previously been able to converse fluently, remained utterly unintelligible to him. Four months subsequently, he began rapidly to reacquire recognition of Italian and Spanish, and had at the time of the paper commenced to give verbal expression in those languages. English and Arabic he had not been able to reacquire either in recognition or speech.

The somewhat venturesome hypothesis that the inferior portion of the third frontal convolution is that immediately occupied as the centre of record and expression of one's native language, while languages acquired later in life find their centre in the remaining portions of that convolution, cannot, by reason of lack of evidence, be entertained. Aphasia moreover cannot be simply explained as the result of a definite circumscribed organic lesion only; there is a dislocation of functional association to be considered, such as is seen in certain forms of aphasia of mental origin, and not due to any organic lesion; in such functional aphasia, too, those centres and tracts will first be restored to activity which, before the aphasia, functionalised earliest and most frequently. As the psycho-acoustic centre is developed prior to the motor speech centre the comprehension of language will necessarily precede that of speech expression, and the reversion to articulate speech coincides with the return or assumption of function of the phonetic articulation centre. In proportion to the more ready activity of the uninjured centres and tracts there will, under favourable circumstances, be a restoration of the faculty temporarily lost, first of comprehending, and then of speaking, primarily the earliest acquired language, and, later on, those of more recent acquisition.

Cerebral Tumours and Mental Affection.

Thoma (*Allgem. Zeitschr. f. Psych.*, Bd. lii., Hft. 6) records three cases of cerebral tumour in which some form of mental disorder was the early and main symptomatic evidence of cerebral lesion, there being none of the usual sensori-motor phenomena to make this condition even suspected during life. His first case was that

of a man aged 52, who, after sundry syncopic attacks, developed melancholia with loss of memory and considerable lack of energy. He died suddenly after having suffered for a few days previously from vertigo and vomiting succeeded by deep coma. Three months only had elapsed between the first appearance of his cerebral symptoms and death. The second case was of a female, aged 58, who was brought to the asylum suffering from delusions of unworthiness and persecution. In this case sudden death also occurred after a few days of spastic paralysis of the right arm and leg and right ocular amaurosis. The duration of the affection was but two months. His third instance was of a female aged 52, whose early symptoms were pains in the back, the occipital region, and both legs, following which there developed delusions of persecution. After severe vomiting, clonic spasms in the left arm and leg and left facial paresis, she suddenly died, the duration of all her symptoms having been but one year. In each case a pronounced mental heredity existed; in the first this showed itself before the onset of pronounced insanity by the irritability and peculiarity of conduct and the morbidly introspective moods of the patient. The second case had had two previous attacks of melancholia. The tumours could in fact only be regarded as causative factors of the psychoses in that they reacted on brains predisposed hereditarily to mental affection. In each case moreover the features of the mental affections pointed to a diagnosis of hysteria when bodily symptoms supervened. The continued complaints, the craving after notice, the exaggeration of the mental symptoms when they thought themselves specially observed, the elaborate and demonstrative suicidal attempt in the presence of others of one of the cases, all lead to the belief that hysteria rather than any organic lesion formed the basis of their affections when certain unexplainable physical symptoms declared themselves. Thoma suggests that these hysteriform symptoms may have been induced by the presence of these tumours, but without discussing that point we may regard the cases as interesting as they show how careful we must be not hastily to regard every hysteriform symptom as one of hysteria.

Syphilis and Nervous Disease.

In the *Zeitschrift f. Klin. Med.*, Bd. xxix., S. 140, Storbeck discusses the assumed relationship between tabes dorsalis and syphilis from a careful clinical and historical investigation of 108 cases of locomotor ataxy, which during three years had been treated in Prof. Leyden's clinic and in private practice. He arrives at the conclusion that an ætiological connection between these affections cannot be maintained. He insists that in his statistical summaries he has been careful to eliminate all sources of error, thus implying that many of the early statistics of others have been unreliable. He divides his cases into three groups, in the first of which he

places all such as both by their history and symptoms gave evidence of an undoubted antecedent syphilitic infection; in his second group occur those cases which he considers doubtful; and in the third section those which neither by their history nor by any objective sign showed traces of precursory specific disease. He then found that of 108 cases of tabes taken from every social grade 22 were certainly syphilitic, 23 were doubtful, and 63 were certainly not syphilitic; that is that only 20·4 per cent. of tabetics were syphilitics as well. By adding one-half of his doubtful cases to the first group he finds that the maximum proportion only reaches 30·6 per cent. The results thus obtained by Storbeck closely correspond with the figures furnished by Westenhoeffer in 1894, who tabulated 72 cases of tabes occurring at the Charité Hospital, Berlin, between the years 1884 to 1893. His percentage of tabetics with indubitable history of early syphilis was 25·6 (which approximates closely to the actual occurrence of syphilis in the population, placed by Naegeli at 22·5 per cent.), and the inclusion of his doubtful cases gave him a percentage of 44, a proportion far removed from that of Fournier (93 per cent.). Storbeck has taken the pains to investigate the tabulated cases of no less than forty-eight authors, whose results vary widely; thus Déjérine calculates that no less than 97 per cent. of tabetics have an antecedent syphilitic history, while Mayer at the other extreme denies its occurrence *in toto*. He regards the high percentages of Fournier (93 per cent.), Déjérine (97 per cent.), Strümpell (90 per cent.), Erb (89 per cent.) and others as untrustworthy, in that many of these, and especially Fournier, have had a wide reputation as specialists in syphilis, and that tabetics thus affected would naturally be led to consult them, and he maintains that his objection is applicable to many other neurologists who have published their results, and who, having a preponderance of syphilitic tabetics brought before them, are driven to wrong conclusions. Storbeck also objects to the acceptance of a syphilitic history from the patient without some definite corroborative objective symptoms pointing to specific disease, and following Kaposi declares that sclerosed inguinal, submaxillary and other glands are by no means indicative by themselves of antecedent syphilis. He draws attention also to the fact that at the inception of tabes when the diagnosis of the affection is still very difficult, there not infrequently occurs a sexual hyperexcitability which may render the patient prone to syphilitic infection, and should syphilis then be contracted and undergo treatment, while some years later definite symptoms of tabes supervene, a follower of Fournier's doctrine would undoubtedly regard the specific disease as the ætiological factor of the neurosis. As a further argument against the syphilitic doctrine he adduces the usual objection that tabetic phenomena are rather intensified than diminished by anti-syphilitic treatment, and he quotes Westphal, who declares that he has never yet seen a case of

locomotor ataxy cured by mercury and iodide of potassium. Storbeck regards the published instances of tabes thus cured as not genuine cases of locomotor ataxy, but as examples of true syphilitic affection of the cord and its membranes simulating tabes. He further mentions cases in which syphilitic infection occurred during the onset of tabetic symptoms, and that anti-syphilitic treatment had a beneficial effect on the former and none whatever on the latter. Were syphilis, he contends, the main ætiological factor in the production of locomotor ataxy it would naturally be expected that a large proportion of syphilitics would later on show tabetic symptoms; but Lewin in investigating the after history of 800 undoubted syphilitic females found that five only were subsequently affected with neuroses, and that of these not a single one was tabetic. Reumont, too, found 290 cases of nervous disease in 3,600 known syphilitics, and of these only 40 were the victims of tabes dorsalis. Whether syphilis may, as suggested by Leyden, predispose the organism by a loss of resistive power to tabes, he declines to consider.

More recently Gluck of Vienna has published a pamphlet on the same subject. His arguments, too, are in refutation of Fournier's syphilitic theory. Relying on the well-known clinical fact that a syphilitic is immune so long as he presents any active grade of specific disease, he shows that were tabes a syphilitic malady a second infection in a tabetic patient would be an impossibility, and the occurrence therefore of recent syphilis in tabes he takes as a proof that the nervous affection is not of specific origin. He also instances the rarity of tabes among negroes and Asiatics, in whom syphilis is most common, and recounts his experiences in Bosnia, where this malady appears to be most rife in certain districts, and where among 3,000 patients with syphilis who had passed under his observation not a single case of locomotor ataxy was to be found.

As bearing closely on this subject it may be interesting to review the arguments of Hirschl (*Wien. Klin. Rundsch.*, Nov. 10, 1895) in the matter of the ætiology of general paralysis. He has analysed 200 cases of general paralysis occurring during ten months in von Krafft Ebing's clinic. The majority of these, all males, were of low social grade. In no instance was the disease definitely attributable to purely mental influences, and heredity was traceable in only 11 per cent. Hirschl admits the possibility of traumatic influences as exciting causes in patients already afflicted with syphilis, but he denies any connection between lead poisoning and general paralysis. The most important causative factor he maintains is syphilis. The antecedent occurrence of this he has proved in 56 per cent., and a probable pre-existence in 25 per cent. of the 175 cases in which reliable histories could be obtained. The incubation period he places at from two to twenty-nine years. He argues that the affection is a purely syphilitic

one, and he supports Obersteiner's view of the analogy of general paralysis with syphilitic perihepatitis, both beginning as inflammatory changes, followed successively by disappearance of the parenchyma, interstitial changes, and eventually atrophy. He regards general paralysis as a late form of syphilis commencing as a syphilitic encephalitis of subacute form, proceeding to syphilitic cerebral atrophy. His view as to the pathology of the cerebral process is based on Lang's dictum that any organ in which a gumma develops must have suffered from irritation in the early stage of syphilis. The contagion residuum in the brains of general paralytics is propagated with renewed vigour owing to the natural hyperæmia of the organ during functional activity, to functional hyperæmia from various mental causes, or to the occurrence of apparently slight traumatic influences.

The *Lancet* of February 22nd, 1896, contains an interesting paper by A. H. Ward on Latency in Syphilis, which may profitably be consulted by those interested in this subject.

Sensory perception at various age periods.

Many investigators have indicated the diminution in sensory perception to be found in so-called degenerates, and Ottolenghi has endeavoured to show that this applies as well to individuals of low social grade. To enhance the value of this psychological inquiry he has (*Zeits. f. Psych. u. Phys. der Sinnesorg.*, Bd. ix., Hft. 5 and 6) published the results of his examination as to the general sensorial function and response to painful impression at various age periods. As stimulus he employed the faradic current, and by means of a faradimeter he was enabled to determine minute variations in electrical strength. He distinguishes various grades of sensibility, ranging through numerous degrees from extremely marked sensory perception amounting almost to a hyperæsthetic state, to a pronounced dulling approaching the anæsthetic condition. His tables appear to show—that the ordinary sense of feeling is fairly well developed in children, but varies somewhat in degree, increases steadily with years, and reaches its maximum at the period of adult life; that in adults there are grades of sensibility which differ not only with small age periods, but also with the social status and what he terms “the degree of degeneracy presented.” It appears further that at an advanced age sensory perception declines markedly, so that response to the faradic stimulation is less even than in children. With reference to pain reaction he shows that the minimal degree of stimulation acting as a painful impression (30-40 volts) was sufficient for some, while others required a higher degree (130 volts) before the sensation was translated as one of pain. There are therefore, as in ordinary æsthesia, widely varying grades of algesic perception. As in ordinary sensation, he finds that the social state and “the degree of degeneracy” influenced the per-

ception of painful impressions. The influence of age periods was more marked in these experiments than in those on ordinary sensation, and he established from his tables that during youth very little pain recognition for the most part exists—a somewhat unexpected result—that pain reaction increases with years, but in contradistinction to his results in general sensibility it does not sensibly decline with old age. Similar experiments on females, though not completed, lead him to believe that sensory perception in them also develops with increasing years, and that the degree of perception between girls and boys of the same age shows no marked difference.

Criminal Anthropology.

Two recent publications (*Iets over Crimineele Anthropologie*, by Prof. Winkler and Dr. J. D. v. d. Plaats: Geneesk. Bladen ii., Nos. 5 and 6; and *De Beoefening der Crimineele Anthropologie en Gerechtelijke Psychiatrie*—an introductory address by Prof. Jelgersma at the University of Amsterdam) present us with a fairly concise *résumé* of the views generally accepted by the followers of Lombroso in his study of the criminal, and mark the degree of interest which attaches to this subject at the present day in Holland. It has always occurred to us that Holland is noteworthy in its possession of some able scientists who are but unfortunately too ready to grasp at the latter day developments of psychology, to parade with some degree of dogmatism the illogical inferences of others. Hypnotism, which for a season held the field, rose through their exertions to the position of a revived science, was vaunted by them as a panacea for every psychic ill, and has finally become consigned to its previous obscurity now that the more alluring doctrines of Lombroso and his school have been placed before them. It is the study of the criminal that now possesses them, they keenly note his every organic degenerative sign and set on it the seal of a psychical meaning, they accept the edicts of “the master” with childlike faith, and strike out for themselves new and startling lines of investigation which by their utter irrelevancy serve to evoke in their less enthusiastic brethren feelings rather of regret than derision.

It has been reserved for an English writer on matters criminal to reproachfully taunt psychologists of this country for the utter lack of interest they display in this new study, merely because they fail to subscribe to the doctrines of the Italian and German schools; but this cannot be considered a very culpable apathy when the reflection is indulged in that the physical investigation of the criminal originated in England and that English alienists prefer to interest themselves not in hasty deductions from utterly insufficient premisses, but in a careful investigation of indisputable facts, before they will consent to commit themselves to any final judgment in the matter. We cannot recognise that Lom-

Lombroso's work is one of pure scientific investigation; its very basis is unscientific. He has never extended his researches beyond the prison walls into the associated mental and physical peculiarities of the normal man, for he has studied the abnormal only; nor has he followed the degenerate child through life to verify those psychic deviations from the normal which he and his followers maintain are the associations of such degenerative stigmata—sufficient is it for them to tabulate certain atypical physical developments and to label them as evidences of psychical degeneracy or abnormality merely because they are found allied at times. This to us appears to be making folly of science. Much we grant may be learnt from a study of the criminal man in his physical and mental peculiarities of type, but the time is not yet ripe for deductions. To specify but a few of the unrecognised factors in the study of Criminal Anthropology, or as Ferri more aptly terms it, the natural history of the evil-doer—we are utterly ignorant of the variations in skull conformation and in facial type induced by certain mental states and specified lines of abnormal conduct; this alone is a subject which requires careful research before we can begin to enlarge on degeneracy and its signs—we cannot as yet explain the occurrence of criminality in the man of normal, mental, and physical development, and of hitherto normal conduct, nor can we yet elucidate the conjunction of a degenerate physical conformation with a healthily working mind, while no allowance whatever is made for that easily observed and indisputable fact that every child during its development from infancy to the adult stage passes from a condition of mere animal existence and from a state akin to that of the savage through successive stages of mental and moral civilisation until it reaches a finality of conduct which we term right or wrong; his environment and education, if evil, may serve to arrest his moral development at any point and make a criminal of him; if beneficial and proper, may make him an honourable man. So long as we neglect to group and classify normally acting man as to his mental characteristics on the one hand and his cranial, facial and other physical features on the other—not in the fanciful mode of Lavater, but accurately and scientifically—so long cannot we venture to deal with him who is acting abnormally. By all means let us store up facts, but let us make no attempt at a deduction until we are certain that we have them all.

Professor Jeghersma accepts and expounds all the doctrines of Lombroso as to the signs and symptoms of criminality with the exception of his theoretical teaching as to criminal atavism. Jeghersma regards the criminal not so much reversionary in type as “a dysharmonic development from the normal.” What, we wonder, is Professor Jeghersma's opinion of Lombroso's doctrine as to the affinity of crime and genius with epilepsy? Professor Winkler in like manner unhesitatingly subscribes to Lombroso's

teachings, and strikes out quite a new departure in scientific medical investigation by calling to his aid the services of a noted mathematician to whom he refers the duty of calculating from the skull measurements he has made of fifty murderers (subjects, the most ardent criminologist will acknowledge, the least likely to present constant "degenerative signs" of value), as compared with the skull measurements of fifty unconvicted persons (another fallacious factor, for any one of these might become a murderer to-morrow), a most entertaining mathematical formula, grounded on the theory of probabilities, from which the readers of this Journal will be pleased to gather that "the chances are 400 to 1 that in a recruit the smaller frontal horizontal measurement will be greater than in a murderer"—certainly a most noteworthy, highly profitable and valuable result. Futile ramblings such as these surely require a rebuke from "the master," similar to that inflicted on Max Nordau for his ingeniously farcical publication entitled "Degeneration."

Has it never occurred to criminal anthropologists to attempt a more rational explanation of the main peculiarities of the criminals they study, and out of whom they make so much literary capital, than to classify their minor abnormalities as evidences of degeneracy? Slang and secret symbols may surely be regarded as elaborate protective measures on the part of the criminal to avoid detection—his abnormalities of handwriting may surely be due to his inefficient or perverted education, his sensory insufficiency and his moral deficiency may be but the results of a neurotic acquirement through years of evil thinking, evil doing, and evil association—we cannot be at all certain that such things are not so, and boldly to assert the contrary without a shadow of proof, and to assume that therefore the criminal is a mental degenerate, and as some even venture to affirm, an irresponsible being who requires moral education and not punishment, all these may be very pleasant as airy theoretical speculations, but they are neither scientific nor logical. The influences of evil education and evil environment are put in the background, to the greater prominence of a speculative condition which for all we know may be but a result and not a cause of his abnormal conduct. So long then as we are unable to satisfy ourselves with the sufficiency of their premisses may we be permitted to hesitate—our hesitancy implies not indifference but merely caution; we know but too well how eager our continental friends, and notably those of Italy and Germany, are to draw large and sweeping inferences from the probably accidental similarity of a few cases, and we fear their minds are but too easily led into self-satisfying conclusions. This is a feminine trait of which they should endeavour to rid themselves, biding in patience for the reputation they are endeavouring to establish as the pioneers of a new science.

CRIMINAL ANTHROPOLOGY.

By Havelock Ellis.

The Elmira Reformatory.

The nineteenth *Year-Book* (1894) of the New York State Reformatory reflects, even at the first glance, the period of trouble from which the Reformatory has only lately emerged. It is a very plain and unpretentious document, without even a single illustration. Although the charges which have been brought against the Superintendent, Mr. Brockway, do not affect the special characteristics of the institution, *i.e.*, the indeterminate sentence and the system of physical and psychic treatment now familiar to readers of this *Journal*, they tended to throw discredit upon the Reformatory, and moreover random and ignorant statements of the case appeared from time to time in England, even in influential medical journals. As the matter has now been fully investigated and finally settled, it may be worth while briefly to set forth the results.

The main charge was of cruel and excessive punishments, and it was supported by a preliminary investigation, practically the work of a single man. In 1894, however, Mr. Flower, the Governor of New York, appointed a committee of three—Dr. Austin Flint and two lawyers, the Hon. William Learned and the Hon. Israel Deyo—who have fully investigated the matter. Three documents resulted: a majority report prepared by Dr. Flint and Mr. Deyo, a minority report—dissenting at certain points—by Judge Learned, and the careful and judicial decision of Governor Flower, who, besides using the two reports as a basis, independently investigated the matter. The first and third documents are contained in this *Year-Book*; the second I have obtained independently.

The committee did its work very thoroughly, and no less than 150 witnesses were examined. As a result the majority report finds that certain defects and errors existed, but at the same time recognises “the magnitude and general excellence of the work that is being accomplished.” The corporal punishment consisted in “spankings,” administered by the Superintendent in person, with a strap twenty-two inches long and three inches wide, and applied to the bare buttocks. Before 1882 it was very rarely employed; since 1889 it has been very frequently applied. The report finds that, assuming that corporal punishment is reasonable, this method was suitable and effective, not involving cruelty, and they only find evidence of excess in one case. They consider also that corporal punishment, under proper restrictions and regulations, is preferable to the modes of punishment which must necessarily take its place if abolished. The chief changes in the Reformatory which they consider desirable are—(1) a decrease in the excessive

population, 600 inmates being preferable to 1,200 (for this, of course, the managers of the Reformatory are not responsible); and (2) the appointment of an assistant to the physician. These changes would make the institution, they say, an ideal establishment. "As it is organised and conducted, however, it is a model reformatory. Its results have been extraordinary as regards its success in the reformation of criminals. It probably stands pre-eminent among the reformatories of the world. These results are due to the unselfish devotion of the managers and the extraordinary qualities of Mr. Brockway as an organiser and an executive officer, added to his intimate knowledge of the criminal character."

Judge Learned, in his minority report, while agreeing at many points with the majority, and fully recognising Mr. Brockway's sincerity and good motives, considers that there was a certain amount of cruelty, although no permanent injury was ever caused, and the strap was only applied to the buttocks. He details a case in which, owing to a misunderstanding between the physician and the Superintendent, an insane man received corporal punishment. He sets forth Mr. Brockway's view of such applications, *i.e.*, not as a punishment, but as a method of permanently influencing nervous action, as of "the nature more of surgery," with reference to the future rather than to the past, not retributive but remedial; he regards it, however, as a method which should not exist in such an institution. He also points out that it was kept in the background, and he refers, quite correctly, to the ignorance of the present writer, some years ago, concerning its use at Elmira. At that period it was, in fact, seldom resorted to.

The Governor's decision, in the main dismissing the charges brought against the Reformatory, is a sensible and sagacious document. He points out, in reference to Judge Learned's conclusion, that "such a conclusion depends largely upon definitions and upon individual sensitiveness. Corporal punishment necessarily implies physical pain, but all pain is not cruel. All the Commissioners agree that the evidence exonerates Mr. Brockway from any cruelties which inflicted serious or permanent injuries upon convicts. . . . In the main he seems to have exercised his authority to inflict corporal punishment with great moderation and care, and his occasional lapses have not justified a sweeping or general condemnation of his methods and practices."

It may seem that this is not a very serious matter to arouse so much disturbance. In English prisons a much larger proportion of prisoners are punished in one way or another, 57 per cent. as against 34 per cent. at Elmira. The Reformatory is, however, a place of international interest and importance, a model which other countries are learning to imitate, and this investigation will have done good service in clearing its reputation from baseless charges, and incidentally also in showing that it is not, as Mr. Tallack and others have idly imagined, a comfortable and luxurious establish-

ment to which criminals are glad to go. (As a matter of fact they much prefer the ordinary prison where no strenuous effort is required of them). It is to be hoped, also, that the investigation will induce the Legislature to put an end to the overcrowding which is really the most serious defect of the Reformatory.

An unavoidable delay in the appearance of this retrospect makes it possible to include notice of the *Year-Book* for 1895. This volume is nearly as attractive as of old. In addition to copious tables dealing with the relations of age, height, weight, breathing-capacity, strength of chest, back, arms and legs, there are a large number of process and other illustrations, showing the men in the gymnasium and reproducing typical examples of the various kinds of foreheads, ears, noses, foot-prints and tattoo-marks commonly found at Elmira. Deficiency of chest development is very marked; 75 per cent. of the men are defective in breathing-power. It is not considered that ear anomalies are more frequent than outside the prison; this, however, is only given as an opinion, and the figures show at least a very large proportion of outstanding ears. Flat-foot is very common; foot-impressions were taken of 529 men, 23 per cent. were absolutely and congenitally flat-footed and 19 per cent. showed an unusually low arch. Tattooing was found among 34 per cent. of the men. Dr. Case, who has examined the inmates for eye-defects, makes some interesting remarks; he finds strabismus very common and attributes it chiefly to lack of symmetrical development due to degeneracy; unequal refraction of the eyes is also common; the interpupillary distance is very frequently either too narrow or too broad, giving a peculiar expression to the eyes noted by Dr. Case, as by many others before him. The average age of 529 men was found to be 20 years 8 months; the average weight 133 lbs., average height 5ft. 5½ in., lung capacity 202 cub. inches, strength of chest 69lbs., of back 270lbs., of legs 375lbs. In all these respects the average inmate of Elmira is far below the average American man of the same age; in height he is even below the average girl student of Wellesley College, and in the other measurements given he is little if at all superior to the girl students.

The whole *Year-Book* bears witness that Dr. Wey and his assistants are anxious to live up to their reputation as almost the only investigators of criminal anthropology outside Europe. Both in England and America the tendency is still to indulge in theory or criticism about criminality, rather than to engage in the more arduous but far more important task of collecting reliable facts on which alone theory and criticism can safely work.

The *Year-Book* is also of interest to English readers because it throws some light on the recent *Observations* of our Prison Commissioners concerning the recommendations of the Departmental Committee. It does this not only by showing the advantages of a reformatory for an older and more radical class of prisoners than

our reformatories are provided for—granted always that the indeterminate sentence is introduced together with genuine scientific treatment—but also in matters of detail. Thus our Commissioners disparage gymnasiums and baths. The *Year-Book* demonstrates that the Commissioners' objections are the outcome of inexperience. At Elmira the advantages of the baths and gymnasium as tonics to the enfeebled nervous system of criminals are more clearly realised every year. Last year all prisoners during the first month after admission were subjected, during half a day, to a daily course of this character, and in appropriate cases (125 last year) the treatment was continued for a much longer period. "It is difficult," we are told, "to formulate in figures or phrases the advantages of baths and exercises, continuously and scientifically administered; it is unquestionably of the greatest usefulness in every way;" a considerable percentage, it is said, without that experience, would break down in health, and deteriorate to a degree of degeneration beyond recovery. The objections imagined by our own Prison Commissioners are non-existent. The questions involved in the treatment of criminals are mainly medical questions, and we still confide the control of this treatment to Commissioners who are exclusively laymen.

"Moral Insanity."

The conception of "moral insanity" and its identification with "congenital criminality" has long been an apple of discord among psychiatrists. It is, however, largely a matter of definition, and Dr. Näcke has recently laid down with much clearness and precision, though perhaps no great novelty, the doctrine of "Moral Insanity" (*"Die sogenannte 'Moral Insanity' und der praktische Arzt," Aertzliche Sachverständigen-Zeitung, 1st July, 1895*). He begins with the proposition, which should now meet no opposition, that "'Moral insanity' as a specific disease does not exist, but what is so called is a variety of imbecility." It differs from ordinary imbecility, because (1) intellectual disturbance is not obvious, (2) there is a predominance of ethical and æsthetical defects; (3) there is an inclination to immoral and dangerous conduct producing conflicts within and without the family; and (4) when congenital there are certain peculiarities in its course. Näcke points out that morality is not congenital, the only congenital element being the aptitude to be morally influenced by education and environment, but this aptitude involves nearly the whole of the nervous system, so that development of morality with defect of the other mental powers is scarcely conceivable. The diagnosis is practically important since moral insanity is more difficult to combat than mere bad environment. The earlier it is recognised and treated the better. The heredity is usually very bad, and sometimes there have been intra-uterine troubles or serious illness during infancy. In spite of care the child is a

ne'er-do-weel in the family and the school. The morbid character of the trouble is indicated by its well-marked periodicity, commonly found in all so-called "degenerative" psychoses. Nor are plentiful indications of degeneration lacking in skull and face and the rest of the body, as well as functional signs such as choreic movements and strabismus. The intellectual condition is decisive as regards the diagnosis between "moral insanity" and ordinary imbecility. If the intellect is but slightly disordered, and especially if there is marked immorality, Näcke considers that we may speak of "moral insanity," but he believes that in every case careful investigation will reveal a lack of mental equilibrium and defective attention, memory, etc. To illustrate the difficulties of diagnosis he brings forward the case of a girl of thirteen, who brought gross accusations of immorality against her father. The father was healthy; the mother had been insane; the girl herself was considered physically and mentally healthy and of normal intellect, though on consulting her teachers it was found that she was regarded as lacking in intelligence, diligence, and attention. She showed no feelings of affection, not only towards her father but also towards her dead mother. She was chlorotic. At first Näcke was not inclined to consider the case one of moral insanity, but ultimately he decided that it might fairly be so regarded. At the same time he admits the probability of an element of suggestion, and the influence of chlorosis and puberty. (The possibility that the accusations were true seems to be fairly excluded, though that is a contingency to be borne in mind.)

In a subsequent paper ("Zur Frage der sog. Moral Insanity," *Neurolog. Centralblatt*, No. 11, 1896), Näcke develops his views on this point in their broader bearings, and with full reference to the opinions of others. He accepts the identification of the "moral idiot" with the "congenital criminal," but considers that in the strict sense this phenomenon occurs so rarely that it would be best to give up both terms. Taking "moral insanity" in the broad sense, he considers that the cases really fall into three groups: (1), The largest group, that of the feeble minded, including both the "physiological" feeble-minded who are still able to earn their own living, and the "pathological" feeble-minded who are unable to do so; (2), an insane group (*Gruppe der originär Verrückten*) which Näcke is inclined to call "paranoid;" (3) moral idiots in the narrowest sense, "degenerates," not insane in the practical sense of the word, but standing on the borderland of insanity, and usually exhibiting many of the physical and psychic signs of degenerescence.

The Dean Case.

The telegraphic news in the London newspapers last year contained frequent references to a trial for attempt to murder which was exciting much interest in Sydney, New South Wales; they were,

however, not very intelligible. A pamphlet has now been issued at the *Sydney Bulletin* office, bringing together all the documents bearing on this case, which is of considerable interest both from the psychological and the medico-legal points of view, with which latter, however, we are not here concerned.

George Dean, 28 years of age, the master of a ferry steamer in Sydney Harbour, was in March, 1895, charged with administering poison (arsenic mixed with strychnia) on several occasions to his wife. He was tried, found guilty, and sentence of death was pronounced. The evidence, however, was not absolutely conclusive, and a certain amount of prejudice was imported by the dictatorial attitude of an unpopular judge. (It was the same judge who tried, ten years ago, the Mount Rennie case, which will still be remembered in England. On that occasion a number of men and boys were convicted—chiefly, as was afterwards found, on the evidence of criminals—of outraging a girl of uncertain character; four were hanged and five still linger in prisons and asylums.) Dean consequently became the hero of a popular agitation, and a Citizens' Defence Committee was formed, forcing the Government to appoint a Commission (consisting of Dr. Sydney Jones, Dr. F. N. Manning, and Mr. Rogers, Q.C.), who practically re-tried the case. The majority of the Commission (the two medical members) reached the conclusion that the wife had for some unknown reason administered the poison to herself; Mr. Rogers, in a minority report, re-affirmed the result of the original trial. The outcome was that Dean, amid general acclamation, received a free pardon. But then fresh evidence began to accumulate; the chemist who (illegally) sold Dean the poison came forward, and it was gradually elicited that Dean's own counsel had by a ruse obtained from him a confession of guilt. (It may be noted in passing that that counsel's love of certainty, and all that it involved, ruined his career.) Dean was consequently tried a third time (the judge not being the same as in the original trial), found guilty, and sentenced to 14 years' penal servitude.

It will be observed that the medical majority of the Commission chose the wrong alternative. Little blame can be attached to them on this account, for the evidence with which they dealt was largely not of a medical character, besides being inconclusive, and it seemed best to them to err, if at all, on the side of mercy. In balancing probabilities they entirely ignored the character and mental history of the man. One of the Commissioners is the leading mental expert in New South Wales, but as the medical Commissioners decided that the man was innocent they naturally refrained from investigating his mental condition. The real medical evidence only leaked out subsequently. On both sides of Dean's family there are signs of unstable mental equilibrium. His father, a police constable, committed suicide merely because a prisoner escaped him. His mother is described by

Dr. Crooke as "mentally weak." She seems, indeed, to have suffered from delusions of persecution, for she had a constant dread of being poisoned; it was said that she would take her own tea and sugar out with her when on a visit, that she sometimes awakened the neighbours by screaming that powdered poison was on the sheets of her bed, and that on one occasion she let herself into a dry well and remained there for a long period to avoid persecution. Her sister is also mentally weak. Regarding Dean's own condition there is not much information. It appears that, as a boy of thirteen, he was convicted (illegally it seems) of using a horse without permission, and sent to prison to associate with criminals for three months. In his photograph Dean's features appear to be anatomically regular, but the expression, though good-natured, is weak and fatuous. There was no adequate motive for the crime; all that could be said was that the couple had lived together unhappily for some months, on account of Dean's dislike of his mother-in-law. It was alleged that he was always kind to his wife and children.

So far as the evidence goes, Dean was clearly sane according to all currently accepted tests. But he seems to have possessed a certain degree of feeble-mindedness, ultimately showing itself in his easy and callous indifference to moral considerations when an obstacle stood in his way, whether or not he may fairly be regarded as coming within the class of instinctive criminals. Such a case is worthy of attention, if only as further evidence that when we are compelled to pronounce a criminal "sane" we have by no means necessarily said the last word about him.

The Histology of the Cerebral Cortex in Epileptics and Criminals.

Dr. Roncoroni, an assistant in Lombroso's laboratory at Turin, has recently published a study on this subject ("La Fine Morfologia del Cervello degli Epilettici e dei Delinquenti," *Arch. di Psichiatria*, fasc. i.-ii., Vol. xvii., 1896). In obtaining his material he was assisted by Tamburini, Giacomini, Bianchi, and other well-known workers. He investigated on an average three points in the frontal lobes of the brains of 10 normal persons, two new-born children, 25 epileptics, 11 recidivist ("congenital") criminals, eight occasional criminals, 10 insane persons, and 14 animals. The sections were prepared in accordance with a special method. Of the 25 epileptic brains five were normal; of the 11 recidivists six were normal, or only slightly abnormal; of the eight occasional criminals five were quite normal and the remainder only slightly abnormal. The decreasing order of normality was thus:—Occasional criminals, recidivists, epileptics. The chief anomalies noted are (1) absence or great reduction of deep granular layer, (2) unusual prevalence of large pyramidal and polymorphic cells, (3) frequency of cells in white matter. Roncoroni then proceeds to discuss the significance of these anomalies. Analysing the factors

in epilepsy, he concludes that these anatomical phenomena represent the hereditary element. "The morphological anomaly reveals to us the disordered development of the nervous system, a development which predisposes to chemical alterations, if indeed the same cause does not produce both these disturbances," although the morphological anomaly is not essential. The changes in the criminal brains are the same in kind though less in degree and frequency, and Roncoroni regards them all as morbid changes due to atavism or arrest of development during foetal life.

The Wisdom Teeth in Criminals.

A certain degree of inquisitiveness has been expressed as to the position of the wisdom tooth among criminals. The matter has at length been investigated in considerable detail by Dr. Carrara (*"Sullo Sviluppo del Terzo Dente Morale nei Criminali," Arch. di Psich.*, 1895, Fasc. i.-ii.). He examined nearly 400 criminals of the age of 19 and upward, all belonging to Piedmont, as compared with 57 normal individuals. Comparing normal and criminal persons of the same age, Carrara found the wisdom tooth much more frequently present among normal persons. The percentage number of criminals showing no last molars is nearly quadruple that of normal individuals, according to Carrara's figures. Among normal persons, Mantagazza and Amadei place the frequency of absence of third molars as between 18 and 23 per cent. Carrara, among his criminals, finds it 33 per cent. It may be worth mentioning that Talbot, of Chicago, has found that out of 670 persons the percentage of missing third molars is still higher, *i.e.*, 46 per cent., but Talbot thinks that this large percentage is due to the high proportion of neurotic and degenerate persons in his practice needing special treatment.

This result of Carrara's investigation is interesting, because it does not altogether harmonise with the atavistic view of the criminal as a reversion to savagery. The criminal, it is usually held, has a large and massive jaw. It might have been suspected that his teeth would correspond, but apparently this is not so, and in this respect, at all events, criminals are not so much behind as in front of their normal fellow creatures.

The question, however, is not yet settled, for Ascoli has more recently criticised Carrara's results and brought forward new results of his own (*Arch. di Psichiatria*, 1896, fasc. iii.). He points out that Carrara's subjects were mostly petty criminals who usually show few hereditary degenerative characters, and that they belonged to Piedmont, where the brachycephalic type of skull predominates and affects the form of the jaw. He has himself examined, in the prison at Ancona, 170 criminals, who belonged to all parts of Italy and were mostly guilty of grave offences. He found that for ages above 30 only 8.8 per cent. were absolutely without the third molar, as against Carrara's 22 per cent. and

Mantegazza's 42 per cent. for normal persons in Italy generally. The average was 12 per cent. as against Carrara's 33 per cent. Thus Ascoli supports the atavistic view, and the question must await further investigation.

Instinctively Criminal Children.

A very important branch of criminological study is the investigation of the classes which are most prolific in criminals, especially the class of tramps and vagabonds. To study these it is necessary that someone with scientific aptitudes should actually live among them. It is very rarely, however, that the properly-qualified individual is both able and willing to acquire the confidence of this class of moral cripples, and peculiar value, therefore, attaches to the careful and detailed investigations which have for some years been carried on by "Josiah Flynt," the *nom de guerre* of a gentleman belonging to a well-known and distinguished American family. Hitherto he has only published his results in magazine articles, which possess considerably greater scientific value than we are wont to find in magazines. In the *Atlantic Monthly* for January, 1896, he has an interesting article on "The Children of the Road."

Young tramps, from an etiological point of view, fall into four groups. The first group consists of those whose parents are tramps, and who are born in the road. In this group environment is everything. The second class, not a large one, consists of those who are forced by starvation to beg and pilfer. The size of this group is often immensely over-rated. The third class, a large one, consists of those who are enticed on to the road, sometimes by "penny dreadful" literature, sometimes by a curious *wanderlust* which Josiah Flynt regards "as quite as much of a disease as the craze to steal which is found now and then in some child's character" (it seems a little doubtful whether the victims of *wanderlust* should come into this group), more often decoyed by an older tramp who wants an apprentice with whom his relationship, though the writer does not here make the statement, is often one of perverted sexuality.

The fourth class, small but important, consists of children who possess an intuitive bent towards crime and vagabondage which is "almost uncanny." Josiah Flynt has known about twenty children of this kind whom he regards as "morally delinquent at birth." "These boys have in largest measure what the entire body of moral delinquents possesses in some degree." They are like "dwarfed men born out of due time;" they instinctively possess the skill of "trained criminal artists," and are the delight of the whole criminal world. In physical appearance "most of them have seemed to me to have fairly well-formed bodies, but something out of the ordinary in their eyes, and in a few cases in the entire face. Sometimes the left eye has drooped very noticeably," and one boy could at will "throw a film over the eye in the most

distressing fashion" (apparently an atavistic development of the *membrana nictitans*, not uncommon in some lower races). "The faces were not exactly deformed, but there was a peculiar depravity about them that one could but notice instantly," and which was not visible in the parents' faces, when these latter came under observation. "I believe that the parents of these children, and especially the mothers, could tell a great deal concerning them, and the theorists in criminology will never be thoroughly equipped for their work till all this evidence has been heard."

With regard to the treatment of "the children of the road," Josiah Flynt insists that we need, above all, "the reform of the reformatories." "First of all we must have a humane and scientific separation of the inmates in all these reformatories, for the law of the survival of the fittest in this field means that the partially good will be dominated by the wholly bad." "Second, the management of reformatories should be in scientific hands," and young men and women should be specially trained for such institutions. "There is a moral hospital service to be carried on in penal and reformatory houses." These recommendations (which coincide with those brought forward by the present writer eight years ago as regards both reformatories and prisons) are undoubtedly gaining ground, and must, indeed, commend themselves to all who have the slightest knowledge of these matters.

Dr. Austin Flint, compelled by his duties in connection with the Elmira investigation to devote close attention to the methods of treating criminals, has recently stated his views on the question generally in a presidential address to the New York State Medical Association on "The Coming Rôle of the Medical Profession in the Scientific Treatment of Crime and Criminals." He here eloquently expounds the important nature of "the task to which the medical profession will more and more be called in criminal administration." The treatment of criminals, he goes on to say, is the great social question of the present day. There is no good reason why we should not take advantage of the studies and experience of criminologists and penologists, treating without malice or resentment the criminal as a patient as well as crime as a disease; and there is every reason why we should study crime in our prisons in the same spirit in which we study disease in our hospitals and insanity in our asylums, with the object of curing the curable by reformation, protecting society against the incurable and devising means of dealing with them, preventing the development of criminal tendencies in the young. The day of punishment, based on an extinct theory of revenge, is over, and Dr. Flint quotes, with approval, the words of Laurent, "The physician should be the friend and student of the criminal as he is of the insane; should know how to distinguish the alcoholic, epileptic, insane, the vagabond, and morally insane. The prison may be a prison, and yet be transformed through the results of criminal anthropology."

The International Medico-Legal Congress.

This Congress was held at New York in September of last year. It is said to have achieved a success far beyond the most sanguine expectations of its promoters, and to have given an impetus to the advance of medical jurisprudence which cannot be estimated. Certainly every movement which tends to bring the medical and legal professions into closer touch is deserving of all success. Between 60 and 70 papers were presented at the Congress, more than half of them belonging to psychiatry, criminal anthropology, and allied psychological departments. A few of these papers, of varying quality, have been published in the *Medico-Legal Journal*; it is proposed to print them all in a *Bulletin*, at a price low enough to bring the volume into the hands of all whom it may concern. The volume can scarcely fail to be of considerable interest. Subscriptions (five dollars) are received by Mr. Clark Bell, 39, Broadway, New York.

PART III.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

ANNUAL MEETING.

The Annual Meeting was held in the Rooms of the Association, 11, Chandos Street, London, W., on Thursday and Friday, July 23rd and 24th.

At the meeting on Thursday morning Dr. David Nicolson, President, occupied the chair.

Dr. FLETCHER BEACH, Honorary General Secretary, read the minutes of the last Annual Meeting, which were thereupon confirmed.

The election of officers and Council for the ensuing year then took place, Dr. Oscar Woods, Dr. E. W. White, Dr. A. R. Turnbull and Dr. C. Mercier having been appointed scrutineers. They reported that "the nominations of the Council are endorsed by an overwhelming majority, but two voting papers strike out two of the Editors as a protest against the plurality of Editors."

The PRESIDENT declared the election to have resulted in the following appointments:—

<i>President-Elect</i>	T. W. McDOWALL, M.D.
<i>Treasurer</i>	H. HAYES NEWINGTON, M.R.C.P.E.
<i>General Secretary</i>	R. PERCY SMITH, M.D.
<i>Registrar</i>	J. BEVERIDGE SPENCE, M.D.
	H. RAYNER, M.D.
<i>Editors</i>	A. R. URQUHART, M.D.
	CONOLLY NORMAN, F.R.C.P.I.
	E. GOODALL, M.D.
<i>Auditors</i>	T. OUTTERSON WOOD, M.D.
	E. B. WHITCOMBE, M.R.C.S.
<i>Divisional Secretary for Scotland</i>	A. R. TURNBULL, M.B.
<i>Divisional Secretary for Ireland</i>	OSCAR WOODS, M.D.
<i>Divisional Secretary for South</i> }	P. W. MACDONALD, M.D.
<i>Western Division</i>	

New Members of Council:

G. H. SAVAGE, M.D.	ROBERT S. STEWART, M.D.
E. W. WHITE, M.B.	H. A. BENHAM, M.D.
FLETCHER BEACH, M.B.	J. A. CAMPBELL, M.D.

Attention having been drawn to the fact that two members of the Council had not attended any meetings during the past year, the Council were requested to take action in accordance with Rule LXVIII.

T. Clifford Allbutt, Esq., M.D., F.R.C.P., and John Fraser, Esq., M.B.Edin., F.R.C.P.E., were elected Honorary Members of the Association.

The President announced the names submitted for election as Corresponding Members, and thought that they should immediately proceed to the ballot.

Dr. MERCIER referred to the discussion at the last Annual Meeting, when it was generally felt that some information should be vouchsafed as to the gentlemen whose names were then brought forward. There were members who were unfortunately unacquainted with these names, and it would assist them if information were submitted.

The PRESIDENT said that if any black balls were cast on the submission of the names collectively, a vote would be taken on each separately, and that would be the time for some such statement. He wished to facilitate business by this procedure. If six members of the Association subscribed the nomination papers of these gentlemen it ought surely to be taken as representing a full expression of their worthiness.

The names having been submitted to the ballot *en bloc*, two black balls were found to have been cast; each name was then separately voted on.

In response to the PRESIDENT, Dr. URQUHART said—I have the honour to propose that Professor Leonardo Bianchi be elected a corresponding member of the Association. Professor Bianchi obtained medical and surgical diplomas at the University of Naples in 1871. He was appointed Privat Docent of Pathology in 1877; Assistant Physician to the Neapolitan Provincial Asylum in 1882; Director of the Palermo Asylum in 1887; Professor Extraordinary to the University of Palermo in 1888; Professor of the Psychiatric Clinique and Superintendent of the Neapolitan Provincial Asylum in 1890, where he has established histological, bacteriological and physiological laboratories. The following works are selected from many published by him; and the April number of the *Journal of Mental Science* contains a retrospect of psychological work in Italy for 1895:—*Sopra un' alterazione anatomo-pathologica del simpatico; Sin centri motori corticali del cervello; Sul significato della eccitazione elettrica della zona motrice corticale; Sulla paralisi spinale spastica; Sulle compensazioni funzionali della corteccia cerebrale; Contributo alla Dottrina Della temperatura cefalica; La polarizzazione psichica nella fase sonnambolica nell' ipnotismo; Ist die Vernunft eine ausschliesslich den Empfindungsbereichen der Hirnrinde zukommende Thatigkeit?; La responsabilita nell' isterismo; Semiologia generale delle malattie mentali; Sulla origine infettiva di una forma di delirio acuto; Paralisi Progressiva e frenosi sensoria; The functions of the frontal lobes; and many others.*

I have also the honour to propose that Dr. Johannes Bresler be elected a corresponding member of the Association. Dr. Bresler received his medical education at the Universities of Breslau and Munich. He was Clinical Assistant to Professor von Ziemssen and Professor Grashey; afterwards Assistant Medical Officer in Dr. Kahlbaum's private asylum at Grolitz, in the provincial asylum of Buntzlau, and in the provincial asylum in Kosten. In 1894 Dr. Bresler was appointed Chief Assistant Physician of the provincial asylum at Freiburg in Silesia. The following works have been published by him:—*Zur associirten deviation der Augen und des Kopfes; Ein Fall von infantiler progressiver Paralyse; Die Verpflegung Geisteskranker in Familien; Studium der Medulla Oblongata; Ueber spinal epilepsie [Neurolog. Centralblatt]; Hysterie.* The April number of the *Journal of Mental Science* contains a retrospect of psychological work in Germany during 1895 from his pen. He also writes for the *Anthropologische Centralblatt*, and is a member of the Anthropological Society of Berlin.

I have also the honour to propose that Dr. F. M. Cowan be elected a corresponding member of the Association. Dr. Cowan is M.D. of the University of Utrecht. He was Assistant Medical Officer to the Meerenberg Asylum for three years; afterwards Medical Superintendent of the Dordrecht Asylum for eleven

years. He is now a consulting physician in the Hague. The following works have been published by him :—*Pathological Section of Meerenberg Report for 1881* ; "On Lunacy Legislation," *Journal of Mental Science*, 1883 ; "On General Paralysis in a Woman," *Journal of Mental Science*, 1883 ; "On Typhoid Fever in Insane Cases," *Nied. Tydschrift.* ; "On the Insane in Holland," *Dict. of Psychol. Med. and Journal of Mental Science*, April, 1896 ; "Lunacy Legislation in Holland," *Annal. Med. Psychol.* ; *Report to Spanish Government on Dutch Lunacy Law*. The April number of the *Journal of Mental Science* contains a retrospect of psychological work in Holland for 1895 by Dr. Cowan, who is already an honorary member of these societies :—The Societe de Medicine Mentale de Belgique, the Society for the Study of Inebriety, the Medico-Legal Society of New York.

The nomination papers handed in to the General Secretary were signed by David Nicolson, W. Julius Mickle, H. Hayes Newington, Henry Rayner, D. Yellowlees, A. R. Urquhart.

The gentlemen thus proposed were then unanimously elected.

The TREASURER (Dr. Hayes Newington) then submitted his report, which, with the Auditors' statement, had been circulated among the members, and made a statement as to the Gaskell Fund.

ANNUAL REPORT OF THE AUDITORS.

We, the undersigned, beg to report that we have duly examined the accounts of the Association, with the vouchers, and find the same to be correct. We regret the expenditure exceeds the income by £27 0s. 9d. The item £46 17s. 8d. for miscellaneous expenditure includes a sum of £30 which the Treasurer was called upon to pay, and to which we shall make verbal allusion at the Annual Meeting. We again draw attention to the necessity of due economy being rigidly observed, having in view the further development of the Association and the extension of its sphere of usefulness.

June 15th, 1896.

ERNEST W. WHITE, }
T. OUTTERSON WOOD, } Auditors.

Dr. WHITE thought that the annual report by the auditors should not be a perfunctory duty. It devolved upon him, as senior auditor, to make allusion to the £30 mentioned in their report. That sum was paid for a verbatim shorthand report of an inquiry held by the English Commissioners at an asylum ; and it had been necessary for the auditors to satisfy themselves that this expenditure had been properly made. It was a large sum to be called upon to pay at a moment's notice and on the authority of one of the officers. He had no doubt that the treasurer would clear up the matter satisfactorily.

The TREASURER said the matter had been fully gone into at the Council meeting last year, when a motion was made by Dr. Oscar Woods that the matter had been thoroughly explained. Leaving that aside the only question of principle raised was whether the President and Officers of the Association were entitled to authorise the expenditure of money in an emergency. He himself strongly held the view which he had put before the Council that there were emergencies in which the Association must act before the Council could be called together to give any authoritative power to the treasurer to pay. The occasion in question, was such an emergency in the view of several of those capable of judging. He had agreed to pay the money on condition that the direct authority of the President was obtained. He thought it was one of the privileges of a President to take the law into his own hands in an emergency. He would be a very foolish man if he took a step that could not be justified by events ; but, if he felt he was justified, it was due to his position as President to authorise a payment without being very severely taken to task for so doing.

The PRESIDENT agreed with Dr. Newington that the President should have some power to take the law into his own hands in an emergency without being penalised afterwards. The incident, however, would no doubt render officers extremely cautious before agreeing to the expenditure of large sums.

Dr.	Expenditure.		Income.		Cr.
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	
To Journal, Printing, Publishing, Engraving, Advertising and Postage ...	486 9 10		By Dividends ...	190 15 6	8 2 8
Examinations, Association Prizes, and Clerical Assistance to Registrar ...	75 2 0		" Sale of Journal ...	20 17 0	
Petty Disbursements, Stationery, Postages, &c. ...	44 9 6		" Handbook ...	8 3 6	219 16 0
Annual, General, and Divisional Meetings ...	100 14 8		" Advertisements ...		
Rent of Premises at 11, Chandos Street, and care of Office, &c. ...	45 2 0		" Fees, Certificates of Psychological Medicine ...	57 15 0	
Furniture Purchase ...	10 12 9		" " Proficiency in Nursing ...	64 4 6	121 19 6
Audit and Clerical Assistance ...	8 8 0		" Subscriptions ...		490 17 6
Law Charges—Registration ...	50 0 0				840 15 8
Miscellaneous ...	46 17 8	867 16 5	Balance ...		27 0 9
		<u>£867 16 5</u>			<u>£867 16 5</u>

BALANCE SHEET—31st December 1895.

Liabilities.		Assets.	
£ s. d.	£ s. d.	£ s. d.	£ s. d.
Journal Account, balance of ...	37 12 4	Lloyd's Bank :—Bankers ...	126 19 2
Examinations Account, balance of ...	18 11 0	Consols (£306) value at this date ...	325 17 9
Petty Disbursements Account, balance of ...	21 4 1	Fees Account, balance of ...	7 7 0
Meetings Account, balance of ...	5 9 3	Sales Account, balance of ...	110 12 0
Rent Account, balance of ...	10 0 0	Subscriptions Account, balance of ...	70 17 6
Miscellaneous Account, balance of ...	9 2 9—		
Gaskell Fund Account, Dividends ...	10 16 0		
Balance :— Balance 1st January ...	559 17 8		641 13 5
<i>Deduct:</i>			
Balance of Revenue Account ...	£27 0 9		
Correction of Subscription Account ...	5 5 0		
Subscription written off ...	7 17 6—		
	<u>519 14 5</u>		
<i>Add:</i> Increase in value of Consols...	9 3 7—		
	<u>528 18 0</u>		
	<u>£641 13 5</u>		<u>£641 13 5</u>

Examined and found correct, ERNEST W. WHITE, } AUDITORS.

H. HAYES NEWINGTON, TREASURER.

The report of the treasurer was then unanimously adopted.

The PRESIDENT then announced that the Gaskell Prize and Gold Medal had been gained by Dr. William Richard Dawson, of Farnham House, Finglas, Co. Dublin, a graduate in Arts and Medicine of Trinity College, Dublin. He was glad to state that the examiners gave a very high report of the results of the examination. He expressed the hope that this result was but the augury of Dr. Dawson's greater success in the future.

The PRESIDENT then called up Dr. Dawson and presented him with the Gold Medal.

The successful candidate, for the Bronze Medal and Prize of Ten Guineas of the Association, was announced to be Dr. John Turner, Senior Assistant Medical Officer, Essex County Asylum, who had submitted a paper of great merit.

THE REPORT OF THE CRIMINAL RESPONSIBILITY COMMITTEE.

"The Committee have felt from the outset that to them has been entrusted a task of great delicacy and responsibility. The subject committed to their consideration is not only intrinsically of great difficulty, but is one as to which much feeling has been aroused, and strong language has been used both by legal and medical authorities. A heavy responsibility rested, therefore, upon the Committee to avoid raising prejudice, to guard against injuring the medical profession, either by advancing statements that could be controverted, or by countenancing the view that medical men are less solicitous than any of their fellow citizens for the protection of the community from criminal and hurtful acts, whether committed by sane or insane persons.

"In considering whether good grounds exist for formulating a demand for an alteration in the law, your Committee feel that the Association should walk very warily, and make very sure of every step of ground traversed, especially as the law which it is proposed to alter, though it has been subjected to much criticism, has yet for many years given general satisfaction to very high legal authorities.

"The task allotted to the Committee appeared to be twofold—first to show what disadvantages, if any, result from the present state of the law; and second to suggest such an alteration in the law as should obviate these disadvantages.

"To the first portion of their task the Committee have devoted much labour. Guided by the principles above stated they set themselves to inquire:—First: Whether to insane offenders justice is done? Second: If it be not, whether this failure of justice is due to the state of the law? The next step would be to show that improvement could be made by an alteration in the law.

"With respect to the first inquiry, whether to insane offenders justice is done, the following statistics have a direct bearing.

"In the return relating to the Prosecution of Offences Acts, ordered to be printed by the House of Commons, on the 7th of April, 1893, the Director of Public Prosecutions reports, at page 16, that the number of charges of murder brought to his notice in the three years 1890, 1891 and 1892 was 209, which were disposed of as follows:—Verdicts of wilful murder returned, and sentences of death passed, 55; found to be insane, 51; verdicts of not guilty, 40; found guilty of manslaughter or of some crime less than murder, 63; total, 209.

"It will be seen that the number of prisoners found insane was very nearly equal to the number found guilty of the capital offence; and these very striking figures are a positive and unanswerable refutation of the notion that the plea of insanity is habitually overridden, and has but little chance of success.

"The Committee proceeded to investigate the actual facts of the trials in a large number of these cases, a work of great labour and difficulty, as the facts had to be unearthed from reports in local provincial newspapers. This investigation showed beyond question that, in the actual trial of prisoners, the judges generally have not hesitated so to interpret the law as to bring within its exonerating scope cases in which its narrow literal interpretation would have had a different result.

"The result, of the inquiries that have been described above, was that the Com-

mittee felt the ground for a demand for an alteration in the law was dissolving beneath their feet. They found that, as a matter of fact, there did not exist any such amount or degree of injustice to insane offenders as would warrant an application for an alteration in the law. They felt that it was hopeless to expect that any fruitful result could follow an agitation for a revision of the law, unless that agitation were founded upon the fact that the law does in actual practice lead to the improper conviction, as ordinary criminals, of insane offenders. And this fact they failed to establish.

"Still, however, your Committee felt that, although unable to discover a positive failure of justice towards insane offenders, it yet ought not to separate without having thoroughly investigated the state, not only of the law, but of the procedure under the law, with a view to pointing out defects and making suggestions for improvement. The result of their inquiries in this matter is embodied in the following propositions :—

"The first step in criminal procedure is to bring the accused before the magistrates. In every case in which an accused person is brought before a magistrate on a capital charge, the director of public prosecutions is instructed to take charge of the prosecution, and in every such case in which the existence of insanity is alleged or suspected, it is the duty of the same official to cause full inquiry to be made; to secure the attendance of witnesses; and to take steps to ensure that the whole of the evidence is fully brought before the jury.

"Your Committee regards this recent improvement in procedure as a very important safeguard against the improper conviction and punishment of insane offenders.

"The next step in criminal procedure is to bring the accused before a judge and jury, and, if insanity in the prisoner is alleged or suspected, then the first question that arises is whether he is in a fit condition to be called upon to plead to the indictment and to take his trial.

"In trying this issue it appears that the judge is not embarrassed by any rigid formula, but is left free to direct the jury in such terms as he may consider suitable for the purpose of giving effect to the general principles of law applicable to the case.

"Your Committee would consider it very inadvisable to impose any restrictive condition upon the discretion of the judge.

"When a person indicted for a criminal offence is declared to be in a fit mental condition to be called upon to plead to the indictment, the trial proceeds, and the issue to be determined with respect to the sanity of the prisoner is, under the provisions of the Trial of Lunatics Act, whether such person was at the time of the commission of the offence of which he is found guilty, 'insane, so as not to be responsible according to law for his actions.'

"It will be remembered that at this trial it is the duty of the public prosecutor to secure the attendance of the necessary witnesses, and to take steps to ensure that the whole of the evidence is fully brought before the jury.

"It is generally held that the leading authority by which the judge is guided in directing the jury upon this issue, is contained in the answers returned by the Bench of Judges in the year 1843 to certain questions put to them by the House of Lords. It is upon these answers that the controversy as to the propriety and justice of the law has arisen and continued. Into this controversy it is not the province nor the intention of this Committee to enter, but the following observations must be made.

"1. Judges of the highest eminence have greatly doubted the constitutional propriety of putting abstract questions of that kind to the jury and of getting such answers from them.

"2. In the words of one eminent judge: "The terms of those answers are not incapable of being so interpreted as to do terrible injustice." And in those of another eminent judge: "The law with respect to the responsibility of criminal lunatics seemed to him in a very unsatisfactory state, and in saying this he had not spoken only his own views upon the matter, because more than one of the judges had expressed the desire that the subject should be reviewed."

"3. On the other hand, the late Mr. Justice Stephen held the opinion that those answers are capable of being "construed in a way which would dispose satisfactorily of all cases whatever.

"4. As already set forth, it appears that as a matter of fact the terms of those answers at the present day are either so construed or so avoided as to dispose satisfactorily of the cases which come before the courts.

"As to the desirability of attempting to supersede the law which is contained in these answers, the Committee have already given a definite opinion. That opinion may now be reinforced by the consideration that the whole of the controversy that has raged around this question, and the whole of the dissatisfaction that has for so long been expressed with the law, have arisen from the putting and answering of abstract questions upon matters not actually *sub judice*.

"Your Committee are constrained to concur in the objections that have been alleged against this course, and cannot but think that the framing and answering of new abstract questions, if it could be brought about, would be but the beginning of a new controversy and of new heart burnings.

"In corroboration of this view your Committee beg to point out that the judges have on their part shown themselves fully alive to the objections alleged against the existing law, but that they have not been, nor is it likely that they ever would be, agreed upon the changes that, if any, are desirable:—That, in fact, some of the ablest and most eminent judges have taken diametrically opposite views of the effect upon the law that would be produced by a given change in its wording.

"It is very important to remember that in the year 1874 a well and carefully considered attempt was made by great legal authorities to restate and codify the law with respect to the effect of madness in cases of homicide; but that, after taking the evidence of witnesses of the highest eminence, the attempt was reported against by a Select Committee of the House of Commons. The framing of a satisfactory formula, capable of universal application, would appear well-nigh impracticable.

"Supposing the prisoner to be convicted at his trial, and that the plea of insanity has been successful, there is, as has been said, no reason to suppose that this non-success is due either to any undue severity of the judge, or to any narrowness or undue strictness in his interpretation of the law, or in his application of the rules of procedure. It is due, in all the cases that have been investigated, to weakness of the evidence of insanity; and when the natural reluctance of juries to convict of the capital offence is considered, it can scarcely be regarded as a matter of regret that they conform to the obligations of their oaths, and convict a prisoner upon the evidence before them.

"Even after conviction and sentence the matter is not irrevocable. It may be that the defence has not been conducted with sufficient skill to exhibit the unquestionable insanity of the prisoner. It may be, and much more commonly is, that there has been a conflict of medical evidence—that the case is one of uncertainty, in which legitimate difference of opinion may exist and does exist, in the minds of skilled observers, as to whether the accused ought or ought not to be considered responsible for his act. In all such cases a very careful investigation is made after the trial, and it is in such cases as these that the Home Secretary and the judge have given the prisoner the benefit of the doubt; and these are the cases in which the sentence has been commuted and the verdict overridden.*

"Lastly, when the convict is committed to prison and is working out his sentence, he is still subject to medical supervision, and a watch is kept upon him for the supervention of the symptoms of mental disorders. The recent Departmental Committee on Prisons has, among other recommendations, made the following:—'The candidates for medical appointments in prisons should be required to show that they have given special attention to lunacy, and that the medical staff in Holloway and other prisons similarly circumstanced should be strengthened.'

* The number of cases in which condemned prisoners have been subsequently reprieved on the ground of insanity during the 30 years to 1894 was 31.

"Also—" That weak-minded prisoners should be, as far as possible, concentrated in special prisons and should be under medical supervision; and that it should be considered whether it is right to treat such persons as ordinary criminals."

"It appears, therefore, that from the time of his first appearance before the magistrates to the time of his acquittal or the completion of his sentence, the mental condition of a person who is accused of crime, and especially of capital crime, is the subject of solicitude to the Executive.

"So far from finding, as has been alleged, that difficulties are placed in the way of proving the insanity of an offender; that judges are prejudiced against the plea of insanity, and conduct trials in such a manner as to nullify that plea; that the law is such as to bear hardly upon the insane offender, even when the judge is willing to bring him within its exonerating provisions; that medical experts are silenced by the rules of evidence and prevented from stating their real opinions of the prisoner; so far from discovering this state of affairs to exist, your Committee have to report that, from the beginning to the end of the proceedings, care is taken that justice should be done, and that the interests of the prisoner should not suffer through the poverty, stupidity, or ignorance of himself or of his relatives.

"Under the state of circumstances disclosed by their investigations, your Committee are unable to make any recommendations for the amendment of the law."*

The PRESIDENT said that this was the fruit of a great deal of work on the part of the Committee, and especially on the part of the sub-committee to which was relegated the duty of drawing up the Report. The subject was not one for excited action, but ought to be dealt with in a calm and considerate manner. The following statement had been handed to him: "While the Irish Division of the Medico-Psychological Association is not prepared to recommend that there should be an alteration in the law defining criminal responsibility, it is of opinion that the procedure now frequently adopted in England and Scotland of having all criminals in whom there is the least suspicion of insanity thoroughly examined by medical experts before their trial, and as soon as possible after the commission of the crime, should be universally adopted, and that their evidence, whether for or against the prisoner, should be laid before the jury. It is also of opinion that more latitude should be given to medical witnesses to explain fully their exact opinion of the mental condition of the prisoner, subject, of course, to the closest cross-examination.—(Signed), CONOLLY NORMAN, Chairman."

Dr. MERCIER, Secretary of the Committee, said: "Mr. President, the matter of this Criminal Responsibility Report stands thus. A Committee has been appointed, and has presented a Report to the Association. The motion was made by myself, and seconded by Dr. Rayner, that the Report be adopted. That was met by Dr. Weatherly with a direct negative. The question before the meeting at the present time is "That the Report of the Criminal Responsibility Committee be adopted." The Report met, on its first publication, with a very hostile reception, a reception which, I think, has since been seen to have been due largely to misconception of its nature and partly to errors of fact; and which has to a very large extent (I say it with confidence) died away; and whatever remnant of opposition there may still remain to the Report will scarcely survive a perusal of the masterly and exhaustive memorandum by Dr. Orange which appears in the current issue of the Journal. Dr. Weatherly—whom I regret not to see present—upon the first reading of this Report indulged in several similes. He compared me to a rat, and he compared himself to some variety of dog. I do not know whether in his calmer moments he would adhere to these expressions, but I venture to submit that similes of that character do not carry very great weight when addressed as arguments to a scientific association upon a scientific subject; and when it is remembered that this subject excites a considerable amount of interest outside the bounds of this Association, and outside the limits of our profession, it will scarcely enhance the respect with which our deliberations are regarded by a sister profession, if they are attended by these zoological metaphors. Dr. Weatherly made a great

* This paragraph was altered on the adoption of the Report.

point of the change of opinion which the Committee underwent after its first meeting ; and although the Association, under the guidance of Dr. Yellowlees, has decided that it need not take account of the matter, yet I feel that some explanation is due to those members who were unable to take part in the later deliberations of the Committee, of the change of opinion which undoubtedly did take place. The first meeting of the Committee was to a large extent dominated and inspired by the ardent spirit of Dr. Weatherly, that is to say there was a very great deal of enthusiasm and there was not a very great deal of knowledge ; and, under the influence of that spirit, the Committee came to a conclusion which it afterwards regretted. I can conceive it to be possible that Dr. Weatherly himself may sometimes say things which he afterwards wishes had been left unsaid. When members object to this Report, I would ask them to what portion of the Report is it that they object ? I have not seen that the facts are disputed : I have not seen that the conclusions are controverted. What I have observed is that there is a great deal of vague dissatisfaction with the Report, because it runs counter to preconceived notions. Now, the cardinal point of this Report is to be found in the first paragraph of page 3. The Committee there say that they felt it was hopeless to expect that any fruitful result would follow an agitation for a revision of the law, unless that agitation were founded upon the fact that the law does in actual practice lead to the improper conviction, as ordinary criminals, of insane offenders. Does any member present contravene that ? Is there any member of the Association who is prepared to go to the Legislature and demand an alteration of the law, without being able to say that the law in actual practice works injustice ? If there is, then I will undertake to say that there are other members who are not surprised that the Committee decline to accompany him ; and I will go further, and say there may be members present who would be interested to stand by and see the reception which such a demand would meet. But is it a fact—and this is the pith and marrow of the whole Report—is it a fact that there does exist any such amount or degree of injustice as would justify a demand for alteration of the law ? If there be, all I can say is that the Criminal Responsibility Committee, after a careful investigation, has failed to discover it. Cases have been found, no doubt, in which it appeared at first sight that the plea of insanity was not established when it might have been, but further investigation showed that this arose because of either a weakness or a direct conflict in the medical testimony. Rare and exceptional cases there were, no doubt, in which this did not appear to be the reason ; but are we to demand an alteration of the law because of the occurrence of rare and exceptional cases ? The Report does not say that we should not make such a demand, but that such a demand, made on such a basis, would have no prospect of success. Is any member prepared to assert the contrary ? Of course, we make no claim to be infallible. We have done our best to discover such cases and we have failed. But if others are dissatisfied with that failure, let them try. The material which was open to us is open to them ; let them make the investigations, and if they find an amount of injustice which would justify a demand for an alteration of the law, this Report does not shut the gate in their faces. All that the Report concludes with is that we are unable to make any recommendation to the amendment of the law ; but that does not preclude other persons at a future time and under other circumstances from making such a suggestion. Those who object to this Report are bound to point out what it is that they object to, and what are the grounds of their objection. The object of the appointment of this Committee was to have the facts calmly investigated, and the reason for its appointment was that there existed in the minds of members a large volume of vague dissatisfaction with the law, and they desired that the facts should be accumulated and marshalled to support that feeling. The Committee claim that they have investigated the facts to the best of their ability, that they have accumulated and marshalled them, and, if the facts fail to support the preconceived notions of members, they are not to blame. The fault is in the facts themselves ; and I submit that this Report ought not to be discarded unless some error of fact can be found in it, or unless some conclusion can be found which is not supported by the facts. If such defects are not found, then I submit

that we are entitled to have this Report adopted by the Association. It has been complained against us that we have acted the part of Balaam, the son of Beor; that we were called upon to curse this law and that we have blessed it altogether. On the contrary, the Association has asked our advice and assistance, as Ahab asked the advice and assistance of Micaiah, the son of Imlah. It wanted us to say, "Go up to Ramoth Gilead and prosper, for the Lord shall deliver it into thy hand;" and because we refused to prophesy smooth things, and foretold the inevitable disaster that must follow, then the precedent of Ahab is to be followed, and we are to be fed upon the bread of affliction and the water of affliction. Well, Sir, we all know what was the result of that course being followed, and how the dogs licked the blood of Ahab by the pool of Samaria. I shudder to think, Sir, of the fate which awaits you if you follow the advice of that false prophet, that Zedekiah the son of Chenaanah, now reincarnated under the style and title of Dr. Weatherly. I have one more appeal to make and I have done. This Committee made a report to the last Annual Meeting, and claimed that, having made that report, it expired. Its claim was not admitted; it was called back to life; its existence was prolonged in spite of itself. I now renew that appeal. We have presented our Report; our labours, I claim, are over, and we are in very truth at this moment defunct. Nay, more: we have expiated our offences in purgatory, with Dr. Weatherly officiating as chief tormentor, and we are now entitled to enter into our everlasting rest.

Dr. OSCAR WOODS asked whether any of the other divisions had expressed any opinion with regard to the Report.

Dr. TURNBULL, speaking for the Scottish Division, of which he is Secretary, said they had discussed the Report, but did not understand that they were expected to announce any decision. He understood the feeling of last Annual Meeting to have been that the Report should be disposed of at the meeting of this year.

Dr. MACDONALD (Secretary of the South Western Division) believed their decision was that the Report should lie on the table.

The PRESIDENT: That is to say, the table of the South Western Division.

Dr. WOODS: I was one of those who started this question in Dublin two years ago; and was very much inclined to take Dr. Weatherly's view. However, there is no doubt that the matter has been very ably investigated, and I certainly would not now be prepared to refuse to adopt that Report. It seems to me that those who have had most experience have gone into the matter very thoroughly, and have given us a very able Report; while we who held the opposite opinion have not laid sufficient facts before them to justify their accepting our views. I am now convinced that the time has not yet arrived when material alteration ought to be made in the law. I quite endorse the opinion expressed by the Irish Division that if the procedure were somewhat altered and every case of doubtful sanity enquired into in the very earliest stage, and if the onus of proving insanity were not cast upon the unfortunate criminal, it would be better. The accused might be poor or might not have opportunity of having his friends properly instructed as to his defence. I think that the Government should put forward experts to state, either for or against the prisoner, the exact condition of his mind. Having heard all the facts and having served on the Committee, although I was unfortunately able to attend only one meeting, I second Dr. Mercier's proposal that the Report be adopted.

Dr. YELLOWLEES: I deprecate that result very much; and I think that Dr. Mercier asks too much. We owe him great gratitude, because he really has been the moving spirit of that Committee and has done a great deal of good work; but we should not necessarily adopt the Report because it contains very valuable matter, and has been brought together with infinite pains. To myself, and I have no doubt to all of us, the Report is very satisfactory in that it brings to light the fact that no great injustice has resulted from the present state of the law—that is to say, that nobody has been hanged who ought not. I am afraid there have been sad and exceptional instances. But it is a little too much to say that *no* injustice has been done, if a man be condemned to death, and lies for weeks under sentence of condemnation, and is found afterwards to have been wrongly condemned, and

in consequence of medical testimony, is *thereafter* reprieved. I do not think that we can be asked to accept a Report which distinctly approves that condition of matters. We ought I think to receive the Report, and thank the Committee for their labours; but for my own part I would not adopt that Report and homologate, or have the Association homologate, all that it contains. I believe that there is room for much improvement in the present condition of matters, and that the fact that no *substantial* injustice is done, arises, not from the state of the law, but from the wisdom of its administrators, who take a great deal in their own hands in the way of interpreting the statutes. I think that it is most right and wise that they should do so, and while we accept that and rejoice in it, we ought at the same time to be very careful not to homologate or approve the law as it stands, for if the law as it stands were administered rigidly I believe the results would be very different. We ought not, it seems to me, to approve any state of matters which implies the condemnation of an insane person and his detention under condemnation until expert medical testimony delivers him. That happens again and again every year. It is not necessary to enter into the general question; and I therefore simply move that the Report be received and that the Committee be thanked for their labours. That does not commit the Association to anything and gives us all the benefit of the Report which the Committee have made.

Dr. MERSON seconded this without remark.

Dr. MERCIER pointed out that Dr. Yellowlees had attributed to the Report what, in moving its adoption, he had repudiated. There was no word in the Report of approval of the present state of the law. What they said was that they were unable to make any recommendations as to the amendment of the law.

Dr. ORANGE: By the kindness of the Editors of the Journal a memorandum which I put together has been published, and it contains practically all I wish to say on the subject. But as regards Dr. Yellowlees' objection to the adoption of the Report, viz., that it frequently happens that prisoners after being condemned are again examined medically and then respited; the first point is to ascertain to what extent that occurs. Tables have been published in the reports of Broadmoor Asylum for twenty years past showing all these details; and when a statement is made on the subject it is very desirable that the real facts should be extracted from them. Moreover, our President gave us a table of the same description in the address which appeared in the October number of the Journal for last year, where figures with reference to the number of criminals found insane after sentence are given in detail (page 584). Taking, then, cases of murder, and remembering that these refer only to England and Wales, we find that from the opening of Broadmoor Asylum down to the end of 1893, 50 men and 25 women were certified to be insane before trial. (I am now dealing with cases of murder as being more simple than mixing them up with others; but it would be quite as easy to deal with all classes, if that were required). Then 65 men and 60 women were found to be insane by the jury on arraignment. 197 men and 141 women were either acquitted on the ground of insanity before 1883 or were found guilty but insane in the years subsequent to that, in conformity with the Statute passed in that year; 33 men and one woman were reprieved on the ground of insanity; 18 men and nine women were certified to be insane whilst undergoing sentences of penal servitude, their sentences having, in the first instance, been commuted to penal servitude for careful watching, as a result of which they were found insane. Here, then, we have 599 persons accused of murder, of whom, if we take only those who were reprieved, the proportion is rather less than 6 per cent. It was stated, I think, that one half of the whole number accused were first of all sentenced and afterwards found to be insane; whereas if, along with the 34 reprieved on the ground of insanity, we also take the 27 whose sentences were commuted to penal servitude, we find that together they represent but a fraction over 10 per cent. That is to say out of 10 murderers sent to Broadmoor on account of insanity, only one belongs to that class in which the verdict has been altered. Coming next to the question whether it is possible to obviate reconsideration by the Secretary of State of the case after sentence, that is quite impossible. It is the prerogative of the Crown exercised by the Secretary of State. *Every* case of

murder, every case where a man is sentenced to death, is most carefully considered, not only cases of insanity, but where that question has never been raised. They are all most carefully considered by the Secretary of State, who has to give the ultimate decision. And this must be so whatever the state of the law. In the case of a prisoner who pleads guilty—so that there is nothing for it but that he should be sentenced—but who is afterwards found to be insane, the Secretary of State has to decide what is to be done, as he also has to decide in the not unusual case where medical men differ. It has not yet been shown that the reconsideration of a sentence is due to the state of the law. If it were, the Secretary of State himself would be one of the first to propose a change. It is now twelve years since the Public Prosecutor was directed by the Attorney-General to make full inquiry in all cases of murder, and to take care that all the facts, whether for or against the prisoner, should be laid before the court. That has been regularly and consistently done from that time to the present. It may be sometimes done better and sometimes done worse. A letter addressed to me a few years ago by the Public Prosecutor indicates his attitude towards cases of this description. He says:—"I quite appreciate the difficulties to which you draw attention, but I can hardly conceive any legal definition of insanity which would remove those difficulties and be sufficiently and satisfactorily applicable to every such case, or even, I think, to the majority of such cases. It seems to me that on such a point as this the law must be more or less elastic and somewhat indefinite, in short that the question must really be one of fact and not of law. The jury have the facts before them, they have the opinion of medical men, and it is for them, putting these two things together, to form a conclusion as men of common sense. I do not myself, therefore, think, if it could be done, that it would be expedient to create a definition which would in any way limit the wide discretion that is now practically left to the medical witnesses who give evidence, and to the courts that deal with cases of this character." I can only say that in my experience the facts have entirely borne out these expressions of the Public Prosecutor. That being so, I think we may well account for the Report which you are now asked to adopt. Two years ago it was suggested that the best course would be to ascertain whether all cases are satisfactorily disposed of; and then, secondly, if cases are brought forward which are stated not to have been satisfactorily disposed of, we should endeavour to inquire whether that was due to the state of the law or to some other cause. Two years have elapsed and we have not had one such case submitted to us for consideration. We therefore felt justified in saying that, "from the beginning to the end of the proceedings, care is taken that justice should be done." Dr. Yellowlees justly observed that this result is very largely due to the mode in which the law is administered. This matter was carefully considered by the Committee of Judges, who, as the Royal Commission appointed in the year 1879 to consider the Criminal Code Bill, expressed the opinion that this difficulty cannot be successfully avoided by any definition of insanity which would be both safe and practicable, and thus many cases must occur which cannot be satisfactorily dealt with otherwise than by an appeal to the Secretary of State after sentence has been passed.

Dr. MERSON said that Dr. Yellowlees had put the matter so clearly that there was little need for him to say anything in seconding the amendment, but he must add that Dr. Orange seemed to him to have made a speech most strongly confirming Dr. Yellowlees' contentions.

Dr. URQUHART thought it a pity that the matter should go to the vote without some attempt being made to arrive at a conclusion satisfactory to both parties. Dr. Mercier had said over and over again that the Report did not in any way commit them to an approval of the present state of the law. If the Committee would accept an insertion in the last paragraph so that it would read "Under the state of circumstances disclosed by their investigations, your Committee, *while not approving of the present state of the law*, are unable to make any recommendations for its amendment," that would perhaps carry Dr. Yellowlees and his supporters in this matter, so that they could then approve of the Report and come to a practically unanimous finding. He felt most strongly that they

should discredit the answers given by the judges so many years ago. Science had advanced greatly since these answers were given. While he would be sorry that they should expose their ignorance by setting forth any definite statements at present, he could not but think that it would be misleading if Dr. Mercier's asseverations were not embodied in the Report. In dealing exclusively with the major degree of crime he held that the Committee had omitted much from their investigations and calculations. He protested against the Report being held to contain everything that could be said on the question of criminal responsibility.

THE PRESIDENT—It would be impossible for Dr. Mercier to accept this, as he is only expressing the view of the Committee, for which he could not now act. His acceptance of this would only be a personal matter, and unless the Committee met again, I do not see how the Report could be amended in that sense, however much we might feel in that direction. The Report must stand or fall, in my opinion, by its present statements, and by the opinions therein expressed. It would be desirable, no doubt, to find some *via media* by which the result suggested by Dr. Urquhart might be achieved, but in the absence of that we must deal with the two positions before the meeting. If I may to some extent go into what is now ancient history I would remind the Association that this Committee was appointed originally on the top of a proposal that we should make a raid on the Lord Chancellor and explain to him our views on the matter. Here is the Report of the Committee, which, as it was submitted last year, must be regarded as the Report submitted this year. With the expressions in it I most fully agree, and, taking it together with the admirable and complete statement of Dr. Orange in the Journal, I think that we may have every confidence in the statements there made, that they embody the highest possible experience in the matter so far as this country is concerned, and point out the results of an elaborate investigation into the working and the operative results of the law in these cases. The point urged by Dr. Yellowlees is not complete, namely, that it is anything of the nature of an impropriety or injustice that a certain number of individuals should be sentenced to death, and, after lying in gaol for some days or weeks, should ultimately be respited on the ground of insanity from the full effects of the sentence. It would be a still graver injustice if a prisoner who was lying awaiting trial should have his mouth shut by a body of experts going to examine him and asking him if and why he committed the offence of which he was to plead the next day "Not guilty." The first consideration must be the interests of the prisoner, and his mouth should not be shut by his being declared insane and without the right or capacity to plead. The small number of cases in which the prisoner was found insane after sentence, amounting only to five or six per cent., indicates how very closely the actual administration of the law approximated to absolute justice. We have to be extremely careful that, in trying to befriend the prisoner, we do not do him a gross injustice by withdrawing from him his first and most essential right—the privilege of pleading "Not guilty." I feel very strongly on this point because in one case where I had to give evidence and report afterwards, the judge, a man of extreme conscientiousness, wrote to me that our rule was too pliable and their rule was too rigid, so that a *modus vivendi* between the two had to be found. There are many cases, he said, so much on the borderland that medical men might fairly disagree in their estimate if they left out the motive that actuated the individual at the time the crime was committed. Afterwards he said:—"I cannot understand how you came to the conclusion you did in that case. I had sifted the whole evidence and been extremely careful in the whole matter, and I was quite unable to find any atom of evidence of insanity in the course of the trial." I took an opportunity of seeing him and telling him that I had no doubt he was perfectly right in his decision upon the evidence he had, which, however, was only partial; whereas I had evidence much stronger than any he had or could have in court, the evidence, namely, of the man himself and of his wife; and I explained to him how my mind was so satisfied about the straightforwardness of the man and his wife (who had been nearly murdered while their child had been murdered) that I knew he was not in a position to judge fully without this further evidence in the case. He

at once gave way, telling me I was perfectly right, and that he had not considered that aspect of the matter when he wrote to me. So that in trying to do what you can for the prisoner there is some risk of doing him harm, and we have to be very careful to avoid anything that would prejudice the very result we aim at. I am satisfied with the working of the law so far as I have been able to see it, and that, although the dictum of the judges is altogether insufficient, we have nothing better as medical men or as psychologists to submit to the authorities and ask them to accept from us as a proper ground for amendment of the law as it now stands. The expression of the Committee that "they are unable to make any recommendations for the amendment of the law" seems to me the gist of the whole matter, and if the Association can see its way to adopt it, I am sure it is not being misled either by the Committee's Report or the expressions of individual opinion from those in the best possible circumstances for informing themselves on this very difficult subject.

After further discussion it was unanimously agreed that "the Report as amended be received and adopted by the Association." The concluding paragraph of the Report was amended as follows:—"Under the state of circumstances disclosed by their investigation your Committee, while not approving the doctrines and definitions contained in the Judges' answers to the House of Lords in 1843, are at present unable to make any recommendations for the amendment of the law."

PARLIAMENTARY COMMITTEE.

"The Committee begs to report that as the proposed Lunacy Bill has not been produced it has had to confine its attention to the consideration of the best ways of forwarding the various matters on which the Association has expressed its views. The Committee has had three meetings. It has been found impossible to deal with the resolution passed in November, 1893, in favour of the extension of the 4s. grant to pauper cases returned from an asylum to a workhouse. The President of the Local Government Board stated lately, in answer to a question, that such an extension would require separate legislation, which he was not disposed to undertake. The Committee has to point out that such legislation would not be in connection with the Lunacy Law, being a matter of Local Government. The Committee has reason to believe that the authorities are in favour of empowering Visiting Committees to grant gratuities and pensions in cases of death or permanent injury to officers in the execution of their duty, and has therefore taken no special steps beyond adverting to such gratuities and pensions in the resolution below dealing generally with pensions.

"This latter question having been referred to it by the Council, the Committee has considered and dealt most carefully with it, and has framed resolutions on the subject of a scheme for compulsory pensions to all officers. Before doing this, however, it thought it right to ascertain what might be the views of all the persons chiefly interested—much variation of opinion having been shown on the several occasions of the subject being discussed by the Association. A circular was prepared asking for the views of (a) Medical Superintendents, (b) the junior medical staff, and (c) the other officers and servants. The circular was sent to every County and Borough Asylum in England, and the answers showed a remarkable preponderance in favour of such a scheme being pressed on the authorities. Out of 48 answers 35 were in favour, 12 were in favour with slight qualification, and only one was adverse, this being on the ground of a liberal pension scheme being already in working order at the particular asylum.

"On this the Committee invited the attendance of Dr. Cassidy, of the Lancaster Asylum, who had prepared a scheme which commanded considerable support. Dr. Cassidy attended, and was requested to act as a member of the Council *pro tempore*, and the Association is now asked to confirm his nomination.

"The following resolutions were adopted by the Committee:—"That this Committee is in favour of a compulsory minimum scale of pensions for asylum officers and servants, as follows:—A proportion of not less than one-fortieth of salary and emoluments for each year of service by way of superannuation allowance to those

whose duties bring them into constant and direct association with the insane, and who have served not less than 15 years, and are not less than 50 years of age; and to those who are incapacitated by ill-health or injury sustained in the discharge of duty; and not less than one-fiftieth of the same to other officers and servants—the amount in no case to exceed two-thirds of the annual value of salary and emoluments. But this Committee is of opinion that Visiting Committees should be empowered to grant gratuities to deserving servants and to widows and families of officers and servants dying while in the service of the institution.

“A copy of the above was forwarded to the Secretary to the Lord Chancellor and to the Commissioners in Lunacy.

“The receipt of the communication was acknowledged by the Lord Chancellor's Secretary, and the Secretary to the Commissioners wrote ‘That should his Lordship communicate with the Commissioners on the subject it will give them much pleasure to lend their general support to any provision submitted by him which may have for its object the universal and compulsory granting of pensions.’

“H. HAYES NEWINGTON, Chairman.”

The Treasurer also read the Report of the Parliamentary Committee to the Council, which was communicated to the General Meeting by desire of the Council.

“The Committee has considered a further question referred to it by the Council, and reports:—

“As to the Report of the Committee on Scotch pensions. The actuary engaged by the latter has shown such an intimate knowledge of the subject that the Parliamentary Committee cannot presume to review the details of the scheme which he recommends. This being ‘that an arrangement might with advantage be made by the asylums of Scotland with the Royal National Pension Fund for Nurses. On the whole, if a suitable arrangement is made with that fund it would be more advantageous both to the attendants and nurses and also to the asylums themselves, than forming a superannuation fund of their own or purchasing Government annuities.’

“If the Scottish Committee adopt his view there can be no question of the Association likewise endorsing it, but on general grounds the Parliamentary Committee would suggest a doubt whether, as the principle of a half contribution by local authorities is contemplated, it would not be wise to wait a little to see what fortune the English Pension Scheme may have. If it meets with success it is possible that, that which is accorded to England on one side and Ireland on the other will be granted to Scotland—seeing that the onerousness of the duties in the asylums of the respective countries is the same. Thus contributions would be saved to that extent, while it would still be open, if the pensions are not sufficiently liberal, to subvent them by private contributions as now proposed. Indeed, it might be worth while for the Association to consider whether such a system of voluntary contribution by way of addition to definite pensions should not be organised for the whole of the asylum staff in the kingdom.”

The PRESIDENT said the Reports dealt with a somewhat complicated matter, but he had the best reason for knowing that the Parliamentary Committee had given exceptional attention to it, and personally he did not think they could do better than adopt the views expressed by them in their Report. It was a very valuable work, and required persistent effort to obtain the results they were entitled to hope for. He proposed that the Report be adopted.

This was unanimously agreed to.

LIBRARY COMMITTEE.

On the report of the Library Committee being called for, Dr. MERCIER rose to ask, as a point of order, if there was any Library Committee, and by whom it was appointed. He had attended every meeting of the Association, and had never heard of a Library Committee being appointed.

Dr. RAYNER believed the Library Committee was appointed by the Council.

Dr. MERCIER stated that in that case it should report to the Council.

The PRESIDENT considered that it might be thought a little excess of zeal on the part of the Council that they should have the report made to the Association,

but it was believed the Association would be interested to know what had been done in the matter.

Dr. RAYNER reported that all the gifts from Mrs. Hack Tuke and Dr. Lockhart Robertson had been carefully catalogued and arranged in the Association's room for its use. If the suggestion of the Committee made to the Council were adopted it would also be possible to arrange for their being circulated. To make the library practically useful increased monetary help beyond that granted by the Council would be necessary—about £15 more being required. It would also be desirable to appoint the librarian on the premises their librarian, who would be willing to undertake the duties of such work at the rate of £10 per year. Dr. Hay had kindly designed a memorial plate for the books, and they had all been book-plated as well as catalogued.

With a view to guiding the meeting with reference to the appointment of sub-committees, the PRESIDENT read the rule relating thereto (CVI.) He was afraid if the election of the Committee took place that day it would be the means, according to the provisions of the rule quoted, of delaying the matter for twelve months, but he did not see any other course open.

Dr. TUKE asked if it would not be competent for Dr. Rayner as an individual to proceed in the matter.

Dr. WHITCOMBE moved that Dr. Rayner, Dr. Beach, and Dr. MacEvoy be appointed the Library Committee.

Dr. MERCIER seconded.

The PRESIDENT said they had been practically acting as such, and the adoption of this motion was merely a ratification of what had been done.

Dr. HAYES NEWINGTON suggested that they should have power to add to their number.

Dr. YELLOWLEES asked for a little more information about the Library Committee. They were in the position of having a number of very valuable books. What were the Committee to do? He asked what the funds asked for were meant to provide.

Dr. RAYNER said in reply that book repairs would be necessary; they would also like to print the catalogue so as to facilitate the circulation of the books amongst the members, and enable members to know what books were wanted in the desirable event of their wishing to contribute further gifts. If the Report had been brought before the meeting he hoped the question would have been decided what use the Association would make of the library—whether it was merely to remain there as a collection of books accessible to only a few members, or made available to all by circulation. In the latter case rules regulating their circulation would have to be laid down, and the matter of an annual subscription from each member or a voluntary subscription from such as used the books, with similar matters, decided. He thought these details should be left to a small Committee to work out.

Dr. WHITE moved that the Library Committee be requested to make a report as to the way in which the books should be used, whether by consultation or circulation, and report to the Council and to the next Annual Meeting.

Dr. YELLOWLEES seconded, believing it to be needful that the matter should be considered.

The PRESIDENT stated that this was what had been done; it had been the ordinary course to report.

Dr. YELLOWLEES remarked that the motion proposed to give the Council powers to go on and make the library available.

Dr. RAYNER pointed out that in three months' time the Committee would be hampered by want of funds.

Dr. URQUHART stated that they could have £10 to go on with.

EDUCATIONAL COMMITTEE.

Dr. WHITCOMBE presented the Report of the Educational Committee as follows:—"Since the last Annual Meeting the Educational Committee has revised and improved many of the regulations governing the examinations of the Association,

including the syllabus for the examination for the Gaskell Prize ; considered and decided many matters referred to it by the Council of the Association, and asks to be reappointed."

This was adopted, and the Committee reappointed.

On the motion of Dr. MERCIER, seconded by Dr. WHITCOMBE, it was agreed to appoint a Committee for collective investigation, with power to add to their number, the Committee consisting of Dr. Urquhart, Dr. Helen Boyle, Dr. Hubert Bond, Dr. R. Stewart, Dr. G. M. Robertson, Dr. Ernest White, Dr. Hayes Newington, and Dr. Mercier.

ANNUAL REPORT OF COUNCIL.

Dr. URQUHART moved "that the Council prepare a report of the general state and proceedings of the Association each year, and submit the same to the Annual Meeting."

Dr. YELLOWLEES seconded, saying that it was most important that the Association should have from the Council a precis of each year's work.

Dr. WHITCOMBE called attention to the fact that the Council had not had the opportunity of saying a word in the matter. It should, he thought, have been referred to the Council for consideration and report.

The PRESIDENT stated that it had been referred to at the Council's morning meeting.

Dr. WHITCOMBE, however, pointed out that it had been brought up only at the tail end of that meeting.

The motion was agreed to.

HACK TUKE MEMORIAL COMMITTEE.

A communication was read from the Hack Tuke Memorial Committee by the GENERAL SECRETARY:—

"The Hack Tuke Memorial Committee beg to inform the Council that the Honorary Treasurer has received up to the present time £288 in subscriptions.

"This money the Committee propose to hand over to the Medico-Psychological Association for the purpose of offering every third year a prize of money, consisting of the interest on the capital subscribed, for the best essay, the subject of which, being strictly in connection with medico-psychology, shall be chosen by a Committee appointed by the Association at an Annual Meeting. The prize is to be open to the whole world, but essays must be written in, or translated into English. The successful essay to be the property of the Association, and to be published in the first number of the *Journal of Mental Science* issued after the adjudication of the prize. The adjudicators are to be specially chosen for each occasion of the award. If on any occasion no essay of sufficient merit appears, the unawarded amounts to be added to the capital of the fund.

"The Committee suggests that the prize shall be offered for the first time in 1897. If the Council approves of this, the Committee would further suggest that the Council should contribute out of the funds of the Association so much as would make up the prize to the probable future amount, since the fund itself would not by that time have accumulated enough interest. If the Council approves of all the foregoing proposals, the Committee will, on being so informed, take immediate steps for the investment of the fund in the names of the Association Trustees.

"G. FIELDING BLANDFORD, Chairman."

After a discussion, in which Drs. Mercier, Macdonald, Rayner, and Hayes Newington took part,

Dr. NEWINGTON proposed that the Association express its willingness to take over the charge of the fund, without going further by way of resolution meanwhile.

Dr. MERCIER seconded.

This having been agreed to, Dr. NEWINGTON proposed that the Association suggest to the Hack Tuke Memorial Committee whether there were not other and better objects to which the fund might be applied than that suggested. He did not think they should in any way appear to dictate to the Committee which was

a purely voluntary one and had worked hard to get up the fund and to consider the best way of applying it. It had given its opinion on the matter, but he believed it was willing to waive it.

This was also agreed to.

EXAMINATION PAPERS FOR THE NURSING CERTIFICATE.

A discussion then ensued on the resolution passed at the Irish Divisional Meeting on May 7th. It is as follows:—"In the opinion of this meeting it is desirable that the next Annual Meeting should consider the propriety of arranging that in future the papers issued to the Candidates for the Nursing Certificate be valued and marked by the Examiners in each Division of the Kingdom."

Dr. OSCAR WOODS said the resolution was not passed by the Irish Division without a good deal of discussion, part of which had appeared in the Journal. It was admitted by all, he thought, and even by many English members, that considerable improvement might be made in the mode of examining attendants for the nursing certificate. The resolution implied that the test was not a uniform one. He moved that the subject of the amendment of the examination for the nursing certificates be referred to the Educational Committee with a strong expression of feeling both from the Council and this meeting that the matter is an urgent one, and that everything possible be done to secure that the examination should be a uniform test.

Dr. O'NEILL seconded, and said that there was no question that there was a want of unanimity in the systems by which the papers for the nursing certificates were judged, so that many had come to the conclusion that the papers should be examined by those who had set them. This was done in all examining corporations and universities, and he could not see why an exception should be made in the matter of the nursing certificate. The papers might be divided between six examiners for the kingdom. This would be quite satisfactory, as the Assistant Medical Officers who taught the attendants were more or less in touch with the kind of questions expected to be set. He was however prepared to accept Dr. Woods' amendment, believing that it struck at the roots of the system.

Dr. SPENCE said he could not agree that "a strong expression of feeling" should come from the meeting to the effect that the examinations were not properly conducted throughout the kingdom. He thought they were properly conducted. Only one side of the question had been spoken to; but there was another, and that supported by one of the most eminent men in Ireland who had to do with their specialty. Dr. Conolly Norman, when he examined his attendants, passed a very small proportion compared to the successful candidates from small asylums. Of twenty-five candidates he rejected five, a very fair proportion, he thought. He believed there would be great practical difficulty in referring the papers to one person, that would be impossible in connection with this examination. The present regulations, if carried out, were quite sufficient to make the examination a thoroughly satisfactory one. If the first part of the motion to refer the matter to the Educational Committee were put, he had no objection to it, but he felt that the latter part was too strong.

Dr. URQUHART said he would be glad to second Dr. Spence's amendment to delete the latter part of the motion.

Dr. WOODS said that the facts which came to their knowledge at Dublin compelled them to think the resolution was necessary. It was unquestionable that the test at present was not a uniform one.

Dr. SPENCE said the matter seemed to him to be entirely in the hands of those who conducted the examinations. The assessor saw that the examiner did not pass anyone who did not give a good account of himself, and the rules and regulations, if carried out, were sufficient for the purpose.

Dr. RAYNER suggested that the Educational Committee should be instructed to investigate the matter.

Dr. HAYES NEWINGTON pointed out that the matter was already referred to that Committee by the standing orders. Merely to further refer the matter would be useless. He would suggest that the words "with a strong expression of feeling from the meeting" be allowed to remain, but that the rest be left out.

Dr. URQUHART asked how anything in this world was to be made uniform. They had an Educational Committee, composed of men who knew what they were doing, and a Registrar in Dr. Spence who gave his time in season and out of season. He did not believe they knew how much Dr. Spence had done in regard to this question, and surely the least they could do was to support him in what he thought was the right course on a subject to which he had given so much attention. In seconding his proposal he felt quite sure it would be the best line to take in the circumstances. He felt it would be hard that any slur should be cast by the Association on men who had sent up and passed candidates. He himself would not allow any attendant or nurse to appear who had not a fair chance of passing. One nurse who was rejected had come up a second time and passed. He had sent her written papers to Dr. Spence, who kindly examined them and thought they were a fair average; but examiners could not examine thousands of papers.

Dr. SPENCE did not wish that discussion should be burked. If there were any improvements which should be introduced in the mode of conducting the examinations he would be only too willing to join with those who wished them. It was not a personal matter as far as he was concerned; but he thought it a reflection on the Medical Superintendents of the United Kingdom who had examined candidates to be practically told that they let people through whom they had no business to pass.

Dr. MERCIER was quite sure that the recommendation of Dr. Woods and Dr. Finegan, if sent to the Educational Committee without its tail, would meet with just as much careful investigation as if accompanied with that strong expression of opinion which would practically force it to remodel the examination. He did not think such a matter should be determined at the fag end of a meeting.

Dr. CHAPMAN supported the motion as coming from the Irish members of the Association.

Dr. OSCAR WOODS intimated that he had great pleasure in withdrawing the tail which had appeared to create all the dissension.

Dr. YELLOWLEES agreed with Dr. Newington. He was quite sure they never would have the examinations satisfactory with regard to results until the written papers were examined by those who set them. He thought it no reflection on Medical Superintendents and assessors to take this step, as, while human nature remained what it was, there would be men who would pluck their neighbours' attendants. As a matter of fact the examination for the certificate in its results was the most unequal he had known. He thought it might be added that the matter was urgent, and the Educational Committee might consider it at that meeting. Much more might be said profitably on the matter than could be openly said, and from what he knew he believed there was great need for something to be done.

Dr. NEWINGTON said his suggestion was a compromise—that the resolution should be cut in two. He did not propose that the matter should be declared urgent.

Dr. SPENCE did not see much objection to the resolution on that basis, so long as there was no reflection on the examiners.

It was therefore agreed to pass the motion as follows:—"That the subject of the management of the examination for the Nursing Certificate be referred to the Educational Committee with an expression of feeling from the Association that the question is an urgent one."

VOTES OF THANKS.

Dr. YELLOWLEES proposed a vote of thanks to the officers who had conducted the affairs of the Association during the year. It would weary the meeting were he to expatiate on their merits, they had done so admirably. Dr. Nicolson's thanks would be accorded him in the afternoon, so that they need not refer to him till then.

The PRESIDENT, in seconding, mentioned that the Association was that day parting with its Honorary Secretary. The value of his work was well known to

the Association, and they all thoroughly appreciated the unsparingness of the trouble he had taken, and were satisfied that he had done all that was possible to further their interests, sparing neither his time nor his mental powers in their behalf. He would like to add to what Dr. Yellowlees had said a rider to the effect that they parted with Dr. Fletcher Beach as Hon. Sec. with deep regret and wished to express their best wishes for his future welfare and success in life.

Dr. YELLOWLEES said his desire for brevity had made him seem to be unjust. He yielded to none in his appreciation of Dr. Fletcher Beach's services to the Association. He heartily deserved their thanks, and he moved that their best thanks be specially recorded in the minutes for the long and faithful services Dr. Fletcher Beach had rendered to the Association.

This was carried with acclamation.

Dr. FLETCHER BEACH, who was warmly received on rising to respond, thanked the Association very heartily for their kind wishes, and expressed his gratitude for the kind manner in which Dr. Nicolson had spoken of his services in the interests of the Association—a cause which had always been dear to his heart. He had always been deeply interested in the Association, and had been glad to watch its progress. They had now a home of their own, which was not the case when he took office seven years ago. They had also become a Registered Company and had a hundred more members. The work had been great, but it had also been pleasant, and he tendered them his grateful thanks for the appreciation they had been pleased so warmly to express.

THE AFTERNOON MEETING.

On taking the chair at the afternoon meeting, Dr. NICOLSON, after expressions of welcome to Dr. Percy Smith, who had been good enough to undertake the laborious work of the General Secretaryship of the Association, tendered his resignation and introduced Dr. Mickle, of whom he said that "he knew no one more fitted to support the position with dignity, with learning, and with that knowledge of scientific work of which he was so able an exponent."

Dr. MICKLE, having taken the chair, said he had to thank Dr. Nicolson for the very kind way in which he had referred to his name, and to thank the Association for the very gracious and enthusiastic manner in which they had greeted his appearance in the chair. After alluding to the dignity, ability, zeal and energy of Dr. Nicolson during his year of office, and his elevation to the post of Lord Chancellor's Visitor, he asked the meeting to join in a vote of thanks to Dr. Nicolson, and to pass it with acclamation.

The vote of thanks having been accorded, and Dr. Nicolson having appropriately responded,

Dr. MICKLE rose, and after thanking the Association for the very high honour they had done him in electing him to that office, proceeded to deliver his Presidential Address. At its close,

Dr. SAVAGE said he had heard with the greatest regret of the short instalment of the address that was to be laid before them by Dr. Mickle. It was full to overflowing of interest both from the psychological and the practical points of view, and it was matter for regret they had not had the opportunity of hearing it all; but perhaps they would be able to do more justice to it by reading it at their leisure. His duty consisted simply in moving a hearty vote of thanks to the President for his address. It was a subject that interested them all, and one which appealed to every section of the Association, whether from the medical, the psychological, or the criminal point of view—the question of impulses, the question of obsession. Some time ago, at a meeting of the Neurological Society, it was shown that it was not merely the alienist, not merely those associated with neurology, who were concerned with these obsessions. The more the subject was studied he believed it would be found that there were many things besides obsessions of *mind*, that also the very manners of people, the tricks, the style, were obsessions and had to be looked upon as such. Undoubtedly many obsessions, most of them, had an organic basis and relationship that would lead to the discovery of truth in investi-

gation; and it was of great interest to find that Dr. Mickle's experience accorded with that of so many others, that there were obsessions and obsessions; that there were a group of obsessions that were evidently not insanities; that there were tricks of mind just as of body that were practically of no importance; that a man might have a trick of speech and yet be an orator, that a man might have a trick of muscle and yet be athletic, and that a man might have a trick of mind and yet not be insane; in fact, that a great many people who were eccentric had obsessions. He was sure they would agree with him in according a vote of thanks to Dr. Mickle and in saying that they would hail the paper with satisfaction when it was in print, so that they might consider it more fully as it deserved.

Dr. BLANDFORD, who seconded, said he was sure they had heard the paper with great interest, and would look forward to reading it in extenso. He had himself been much interested in the paper and especially in what Dr. Mickle had said about tricks and eccentricities, and the importance he attached to them. He himself believed they were very important. He had known such tricks handed on from father to son, and had also known what had been tricks in the father develop into insanity in the son; and he was sure that none of these tricks and eccentricities were things to be overlooked. It was important that all such should be checked in children at an early age, and with very great care and assiduity repressed during their growing up.

Dr. NICOLSON said it appeared to him a singularly fortunate subject to have been chosen for the Presidential Address, because not only were they dealing with cases of that sort day by day amongst the patients with whom they had to deal, but it was a subject with which they could each individually sympathise as bringing before them those gross deviations from the normal with which they themselves in their weaker moments had to contend. It was therefore of special value to them in the sense that it was one which they could personally interest themselves in, and sympathise with, and analyse by their own self-introspection, because there was no doubt that at many times (more frequently in some cases than others) they were apt themselves to depart from what was their normal best. The subject was an important one also for them to consider so as to be able to deal with apparent deviations of a similar sort occurring not only among their friends and neighbours, but also in those brought to them for official inspection. He concurred with the proposal to accord Dr. Mickle a hearty vote of thanks for his admirable and suggestive address.

Dr. MICKLE thanked the Association for their kind reception of his address.

The PRESIDENT then intimated that Dr Walter Channing was present as representing the American Psychological Association. They were very pleased to see him, and hoped he would join in their discussions.

LIST OF MEMBERS ATTENDING.

July 23rd, 1896.—Members: F. W. McDowall, H. Rayner, Oscar Woods, E. D. O'Neill, T. Outterson Wood, E. B. Whitcombe, D. Nicolson, Fletcher Beach, P. W. Macdonald, W. Julius Mickle, Evan Powell, Ernest White, David Bower, A. R. Turnbull, Walter S. Kay, A. R. Urquhart, D. Yellowlees, J. Beveridge Spence, W. R. Dawson, D. M. Cassidy, R. Percy Smith, John A. Wallis, J. Bayley, Margaret C. Dewar, Chas. Mercier, H. Hayes Newington, James Greig Soutar, F. Sidney Gramshaw, George R. Wilson, Frank A. Elkins, J. O'C. Donelan, W. Rawes, John Havelock, Chas. Caldecott, H. Rooke Ley, J. Murray Lindsay, R. S. Stewart, John Merson, W. Orange, Wilson Eager, James Chambers, T. Seymour Tuke, C. Hubert Bond, R. H. Cole, Heurtley Sankey, W. Ford Robertson, J. Maclaren, David Brodie, D. Mackintosh, Bonville B. Fox, Strangman Grubb, Henry E. Blandford, J. H. Paul, W. Douglas, J. E. M. Finch, Geo. H. Savage, R. Brayn, H. J. Macevoy, G. T. Blandford, H. M. Eustace, W. Andriezen, J. F. Briscoe, T. A. Chapman. Visitors: Bernard Holland, J. E. Taylor.

July 24th.—Members: A. R. Urquhart, Fletcher Beach, R. Percy Smith, A. R. Turnbull, Margaret C. Dewar, D. Yellowlees, F. Sidney Gramshaw, J. Maclaren, John G. Havelock, Charles Caldecott, T. Outterson Wood, T.

Seymour Tuke, John Wallis, H. Hayes Newington, D. Nicolson, H. M. Eustace, D. Bower, E. D. O'Neill, James Chambers, W. F. Robertson, Bonville B. Fox, Oscar Woods, H. Rayner, H. J. Macevoy, W. R. Dawson, Jas. Greig Soutar, G. E. Shuttleworth, H. Stilwell, J. Peeke Richards, J. H. Chapman. Visitor: J. J. Fraser.

DISCUSSIONS.

*Dr. G. R. Wilson on "Weismannism and Insanity."**

Dr. ANDRIEZEN said Weismann's position was, that there was a slow and gradual action on the organism in general, and the changes so produced slowly and gradually influenced the germ plasma. Dr. Wilson seemed to deny any distinction between acquired and hereditary characters. That was neither a commonsense nor a scientific view. Observation helped us to see that the germinal elements which were transmitted for generations were the vehicle for the transmission of something. He also criticised Dr. Wilson's statements as to cell multiplication.

Dr. WILSON, in reply, said that his statement with reference to the limit of cell multiplication was quoted from Minot's (?) *Embryology*, and he could only leave that authority to weigh in their minds against Dr. Andriezen's statement.

Mr. Briscoe's paper on "Heredity in Mental Disease."†

Dr. CHANNING said Dr. Briscoe seemed to him to have said that Dr. Kingsley had asserted that a narrow palate was never found except where there was mental disease. On the contrary, Dr. Kingsley totally disagreed with Dr. Down on this point, and stated that he found more cases of deformity of the palate among patients who came to have their teeth corrected than among the diots he examined with Dr. Down. Many of the statements as to the significance of narrow palate with respect to degeneration were exaggerated.

Dr. Havelock's paper, "A Case of Recurrent Mania."‡

Dr. YELLOWLEES said no doubt they had all known similar cases, and they formed one of the problems of the psychiatric physician. They ought to be able to cure recurrent mania, but they could not. No form of disease had vexed or disappointed him more in individual cases. He had no doubt that the patient, though apparently well, was not truly and physiologically well during the intervals, but that there was something or other accumulating in his brain that implied a speedy explosion. Moreover, anything which engrossed the man and took him out of doors and out of himself would, he believed, have been as efficacious. It was not necessary that circular mania should become cycling mania. Was it not significant, too, that the patient should recover about the age of 54? At the climacteric period these neuroses sometimes exhausted themselves. The cycling had probably just come at the right time when there was a constitutional change occurring in the brain, which probably had quite as much to do with the recovery as the cycling. He himself would not have dismissed the man so often, but would have earnestly urged him to take at least a year of asylum life in the hope that the explosions would become more rare.

Dr. BONVILLE FOX said a question might be raised, which, if it could be answered, would make the time devoted to the discussion well spent, namely, What is the morbid change that underlies the recurrence in recurrent mania? He could only re-echo what Dr. Yellowlees had said, that of all the disappointing cases that tried asylum physicians and their skill and patience, none beat recurrent mania. They most certainly ought to get well, and the condition be checked; but time after time they failed. It was all very well to say the brain was unstable, as, no doubt, it was; but what was the actual change at the recurrence? Was it a vaso-motor change, as had been suggested? He had tried ergot and similar drugs hoping to check the recurrence, but he could not pretend to have had any success in that way. A case still under his care showed recur-

* Printed at page 744.

† Printed at page 759.

‡ Printed at page 817.

rences as marked as in Dr. Havelock's, but the patient was never really well long enough to be discharged. He had recurrences lasting perhaps a fortnight, and then for a fortnight was to all appearance as pleasant a man as could be met; but again he would break down. So long as the patient was insane he worked like a navvy. He could not be said to be as good as an extra gardener, but he pretended to do as much work as one. A good deal of his work was destructive instead of constructive, but he worked all day long, and the very first sign of his convalescence was that he took up a book and gave up his work for mooning under trees, in this respect differing from Dr. Havelock's case. With Dr. Yellowlees he believed there was a certain time of life—he would not say climacteric—when in the male there was a probable breaking up of a morbid process and a possible setting up of stability. An alternative, however, was that the vessels (and he imagined these recurrences must denote a certain change in the vessels) could no longer stand the tear and wear and gave way, so that cerebral hæmorrhage occurred. From even his own short personal experience he could commend cycling as the means of enormous benefit to the circulation and the health generally, both physical and mental.

Dr. SAVAGE also agreed with Dr. Yellowlees about the disappointing nature of recurrent mania and the difficulty of giving any rational explanation of it. What was the relationship between mind and brain in cases where there occurred from twenty to fifty attacks of acute mania of the most violent description, while in the intervals there was no evidence of any intellectual impairment, loss of memory, of self-control or of acquisition? It was a convenient way of explaining these cases to speak of a collection of nerve force and surplusage followed by explosions. He did not believe it. But, while not comprehending these things, one had to recognise them, and the most characteristic points about them were the disappointment associated with them, and the fact that of two cases exactly alike as regards age and excitement one would have recurring attacks of grave severity with no intellectual loss, while the other would have one or two attacks and be left a dement. He was himself a votary of the cycle; but all good had its correlative evil. He had seen serious results in private practice from patients learning to cycle. It should be remembered in recommending cycling that the patient might prove a more brilliant and apt pupil than the nurse, and he had known of the nurse being left alone far behind.

Dr. WHITE said he should have liked to have known the history of the case between the attacks. He thought the patient's literary efforts should have been forbidden. If they still existed they might throw some light on the state of his mind during the intervals. More care should be exercised with regard to supervision of the patient's life and habits after discharge. In recommending cycling he had insisted that the nurse should become thoroughly proficient first, as without careful watching of the patient severe injury might result.

Dr. HAYES NEWINGTON said he had always considered these cases as indicating vasomotor disturbance. The body and the brain had to make mutual arrangements for each other's comfort, and now and then they fell out. That there was a climacteric element to be considered, two or three cases particularly impressed on him. One patient at twenty had been disturbed in his mind; at thirty-five, while a robust, strong man, he had a similar disturbance; between fifty-five and sixty he returned as a climacteric case, but after two years he got well; then for eighteen months he was treated afterwards as a senile case. He had given rather a favourable prognosis in these cases. As to cycling, some years ago they started a club, as many as five sometimes riding a tandem tricycle, the patients in front, the attendant behind. Not merely the physical side should be considered, but also the mental influence of change of surroundings.

Dr. HAVELOCK, in reply to Dr. Yellowlees, said he doubted any other distraction being as effective as cycling in this case. For the frequent discharges from the asylums he was not responsible, but he considered it the right course. The man was more like a patient passing through a severe epileptic fit than anything else, and getting so well that in the intervals he managed a large business with perfect success, but for which, indeed, he would, on his return, have had to come

as a pauper patient. It would have been difficult to retain a man who was urgently required at home, and who was not going to mope and be a burden on society, but to do his duty. As for supervision between the attacks, he no more needed it than any of themselves.

Dr. Stewart's Paper on General Paralysis.

The PRESIDENT said the striking fact with regard to geographical distribution was a valuable confirmation of the fact that, as previous statistics had shown, general paralysis was particularly liable to occur in cities rather than in the country, and especially in those with a large working population, also of towns, such as seaports, with a large aggregation of persons who were in some cases the sweepings of creation and lacking self-control. Dr. Stewart had given valuable confirmation of the effect that general fastness of life and all that it included had upon the production of general paralysis. He seemed to make out very clearly his point with regard to the increase of female general paralysis as compared with male. Up to a certain point statistics had shown a gradually increasing proportion. Dr. Stewart's figures showed that lumping together private and pauper patients there was actually no increase of late in the proportion of females to the total admissions, and that with regard to private cases it was actually a diminishing quantity. Some former writers had declared that general paralysis was absolutely unknown among gentlewomen (using the word in the sense in which it ought to be used). But of late years it had become not altogether unknown, and he was glad to know that that class were freer than they were formerly.

Dr. MERCIER said the final part of Dr. Stewart's paper was extremely valuable, and pregnant with all kinds of suggestions with regard to the prevention of general paralysis. If the principles he advocated could be carried out there was no doubt they could reduce general paralysis to a very small thing indeed. But unfortunately people could not be got to live in what was called a state of "physiological righteousness," they had not sufficient self-control, and it was too much to expect people to do that who were born, as so many seemed to be, to the condition of being fast and loose. The subject of degeneracy had been touched upon, and many of the unfortunate class referred to did show the conditions which in so many cases led to that life which was indeed but the fruition of what in many of them was innate.

Dr. HAYES NEWINGTON protested against the view that general paralysis was chiefly due to wrong living. He could not admit that this generation was much worse than its forbears. He did not see how immorality could increase so suddenly. The change that had taken place within the last 50 years had been enormous. (The President remarked that no one had asserted that general paralysis was chiefly due to wrong living.) Dr. Newington said that at any rate Dr. Stewart's figures were rather used to point that way to the exclusion of some other element they were ignorant of. He considered heredity had as much influence as anything else.

Dr. YELLOWLEES held that the direction in which Dr. Stewart looked for the cause of general paralysis was the truer one; it certainly fitted better with many observations than that of heredity. He had never looked upon general paralysis as one of the most hereditary forms of insanity, although it might be quite true that this generation was not so wicked in special directions as its predecessors; but it was the successor of their wickedness, and the fact that we were not worse than them did not undo Dr. Stewart's position. He was not sure that Dr. Stewart's statistics covered the whole ground of female private patients. A large number of female private patients did not reach asylums at all. If the decrease were a fact, it contradicted the general impression that there was an increasing tendency among ladies towards cigarettes, sherry, and various other things not good for them. The prolonged duration of general paralysis had during the last few years greatly struck him. Patients as to whose being general paralytics he was quite sure, and who according to rule should have speedily died, had gone on for eight, ten, or eleven years, and died as paralytics. The condition seemed to be arrested and the patient have a long period of wellness, able to go about, con-

ducting himself properly, although one was convinced it was a case of general paralysis.

Dr. BRISCOE said he had a patient under his care who had had general paralysis for sixteen years. It was a typical case, the patient having periodical attacks of violence, sending telegrams continually, and writing in an absolutely typical general paralytic style.

Dr. ANDRIEZEN said observation had led him to change his mind with respect to the teaching that general paralysis was one of the least hereditary forms of insanity. The heredities they had been accustomed to look to had been those associated with ordinary psychoses; but in general paralysis there was often a history of quite a different sort—epilepsy, or gross forms of organic disease, Bright's disease, cerebral hæmorrhages and diseases of that sort. Charcot had described general paralytics as belonging to a great neuropathic stock; on the one side being such conditions as tendencies to cerebral hæmorrhages and cardio-arterial diseases, and on the other a tendency to megrim, epilepsy and certain neuroses. General paralysis should not therefore be judged in the same way as ordinary insanities with respect to heredity. There seemed to be some special element which made it more of a gross body and brain disease than the other more subtle psychical disturbances. As illustrating a difference between the two classes the ordinary simple psychoses were common among Quakers and in the Church, while general paralysis was rare.

Dr. STEWART disclaimed responsibility for the figures, which he merely took and drew what he considered legitimate conclusions from them. The fact of general paralysis being common in cities must not be taken alone, but along with the other circumstances under which it was frequent. It had nothing whatever to do, so far as figures proved, with the stress of life supposed to exist in cities, as the increase amongst the lower classes was not so pronounced as in the upper; but it was undoubtedly connected with such factors as drink, sexual excess and venereal disease, seeming to be associated, in fact, with an increase of wealth apart from the knowledge how to use it. It was not amongst the sweepings of creation that the disease was increasing, but in quite another class of society. There could be little doubt it was diminishing amongst gentlewomen, and in fifteen years, if the disease decreased at the same rate, should be extremely rare amongst them. The relative difference between general paralysis and other forms of mental disease in respect of heredity as an etiological factor was that in general paralysis it was present in 16 per cent., in the others 22·8. He referred Dr. Newington to the criminal statistics for 1894, which showed that crimes against morals were increasing, especially in persons between sixteen and twenty-one years of age. There seemed certainly to be now less drinking and drunkenness than before; but general paralysis seemed to be replacing drunkenness. The duration of the disease did not come within the scope of his paper; the change of type was altogether another aspect of the case. He thought it extremely likely that the duration of the disease was becoming more and more prolonged.

*Dr. Turnbull's Paper on "Female Nursing in an Asylum Male Sick-room."**

The PRESIDENT said Dr. Turnbull had brought forward a very important and practical point in the treatment of the insane, and he was very glad to hear how chivalrous his male patients became under female nursing.

Dr. BRISCOE said, that since nursing had in the last decade or two passed through a revolution, they in asylums ought to share the benefit, and he was sure in England the Commissioners in Lunacy would entirely approve the system adopted in the Fife Asylum.

In reply to Dr. G. R. WILSON, Dr. TURNBULL said there were 20 patients in each sick-room.

Dr. SAVAGE said it was often more convenient to place advanced cases of general paralysis and many cases of senile dementia under the charge of female nurses rather than of male. He had patients now under his care who could not be controlled by men, but were controlled as well as possible by female nurses; and the

more highly educated and refined the lady nurses were, the more amenable were the patients to such control. There were, of course, many mechanical difficulties which seemed to have been overcome by Dr. Turnbull's plan; but each hospital and asylum would have to make its own arrangements to meet them. The principle, however, was good.

Dr. Andriezen's Paper.

The PRESIDENT said that Dr. Andriezen's statements about the spinal cord were in accordance with the best teaching of the day, but he did not quite like his inclusion, on just the same lines, of the condition in syringo-myelia with that in tabes and progressive muscular atrophy. It was quite true that in syringo-myelia the intermediate cells were apt to be first affected. It seemed to him, however, that this disease was not a primary affection of the nerve cells at all, but rather a coarse disease which invaded the spinal cord from its central canal, doing so very irregularly. It was like an invading army, it being in many cases a chance which part of the resisting forces it happened to come up against. In some cases it did happen that the cells and structures, connected with the anterior nerve roots or those connected with the posterior, suffered very early in the disease. He would himself prefer, therefore, not to put it on quite the same lines as the other conditions. It was also extremely interesting what already had been published, that in alcoholic insanity or chronic alcoholism (the condition which is brought on in the human being by a definite agent taken in in a definite way) the first cells affected are the polymorphic. That was simply an illustration of the commonplace of pathology that it was the highest and latest evolved form which was least resistant to the forces which tended to break them down. As to the occipital area in the calcarine neighbourhood showing more change than the auditory, Dr. Andriezen would be the first to admit that that must be confirmed by a large number of very carefully carried out observations. He himself was not prepared to take Flechsig's results without further confirmation; they would have to be tested by other capable workers. Even the most capable men brought forward some views and conclusions that were premature, seeing everything that favoured their views and seeming to become blind to what was not in their favour. Whether Flechsig had fallen into that error he did not know, but he preferred to wait for confirmation of his statements. The conclusions about the anterior and middle area of the cortex of the general paralytic being most affected were not new. He had himself proved this to his own satisfaction more than 20 years ago in necropsies carried out with the greatest care. He had taken an average of his cases by measurement to compare the extent of the areas affected by the change which he had many years ago denominated adhesions of the cortex in the various lobes of the brain, and the percentage was by far greater in the frontal and parietal lobes than in any other, and, of the two, greater in the frontal, although not so very much greater, as might have been expected. He took it, therefore, that Dr. Andriezen's recent researches went to confirm those he had made so many years ago.

Dr. ANDRIEZEN agreed with Dr. Mickle with regard to the system diseases of the spinal cord and syringo-myelia, which he merely took as an anatomical illustration of the fact that it was a disease affecting the intermediate cells and the other cells afterwards. The other system diseases, everyone agreed, affected certain areas of the brain. As to the changes in alcoholic insanity, it had been observed even by the naked eye that they also occurred in the posterior cerebral artery. He had not been aware of Dr. Mickle's researches, and his own were therefore of value as independent confirmation.

THE ANNUAL DINNER.

The annual dinner of the Association was held on 23rd July at the Criterion Restaurant.

The attendance was large and included several distinguished visitors.

The President, Dr. Mickle, proposed the health of "The Queen and Royal Family," while that of "The Army, Navy, and Reserve Forces" was responded to by Lieutenant-Colonel Yorke, of the Royal Military Academy, Woolwich; "The Houses of Parliament," proposed by Dr. Yellowlees, was responded to by

Col. Brookfield, M.P.; "The Medico-Psychological Association," proposed by the President; "Kindred Associations and Societies," proposed by Dr. Blandford and responded to by Professor Bastian; "The Visitors," proposed by Dr. Savage and responded to by Dr. Wilkes, President of the College of Physicians; and "The President," proposed by Dr. Nicolson, the ex-President. The speeches were interspersed with music under the direction of Mr Chas. Tinney.

EXCURSION TO WOOLWICH.

After the scientific work of the Annual Meeting had been concluded, a number of the members made a very pleasant excursion on Saturday, July 25th, to inspect the Royal Arsenal and Royal Military Academy at Woolwich. After having been conducted through the Arsenal and having had an opportunity of seeing the wonderful machinery at work in the manufacture of arms and ammunition, the members were driven to the Royal Military Academy, where they were the guests of Lieut.-Colonel and Mrs. Yorke. Colonel Yorke is the head of that important Academy for the training of cadets, and holds rank in the Royal Artillery, one of the two most scientific corps of the Army. After a short rest the members were entertained at a sumptuous luncheon, and drank with enthusiasm to the health, proposed by the President, of their host, the gallant Colonel, and of their hostess. This lady is a sister of the Treasurer of the Association, Dr. Hayes Newington. In replying, Colonel Yorke gave a short sketch of the character of the training carried on in the Royal Military Academy, and of the scientific aims kept in view in that course of instruction. The party was then conducted over the Academy by their genial host. The members were very much struck by the appliances, apparatus, and arrangements made for teaching the cadets and for their physical culture. Each one of the guests on parting conveyed to the host the gratification the excursion had afforded, with thanks for the generous hospitality that had been so much enjoyed.

THE PSYCHOLOGICAL SECTION OF THE BRITISH MEDICAL ASSOCIATION, AT CARLISLE, 28TH TO 31ST JULY, 1896.

The section was opened by the President, Dr. J. A. Campbell. The address was directed to the consideration of "Lunacy in Cumberland and Westmorland," and is printed in full in the *British Medical Journal* of 1st August, 1896.

After some preliminary words of welcome, Dr. CAMPBELL sketched the characters of the population of these two counties, concluding that they offered definite evidence of Scandinavian origin, and were distinguished by high stature, heavy body and brain weight, accompanied by early maturity and early ageing.

Dr. Campbell, from observations on three generations, has noted families improving and practically growing out of insanity. The suicide rate in these counties, he remarked, is high. Illegitimacy is also high, Cumberland standing next to Shropshire in this respect, and he pointed out that seduction was often a first stage in mental degeneration.

The small landed properties held by statesmen or yeomen, he showed, are rapidly decreasing in number, and he expressed his opinion that the tying of families to one spot for generations, together with the consequent intermarriage, tended to produce general degeneration and insanity. He emphasised this by alluding to the development following change of location.

Dr. Campbell next gave a sketch of the Garlands Asylum and its development, from 1862 to the present time; the last addition being the erection of a house for private patients, under section 255 of the Lunacy Act, 1890.

The increase of insanity was next touched on, and figures were quoted which in Dr. Campbell's opinion "clearly show that insanity cannot be said to be on the increase in these two counties." The statistics of Garlands Asylum show that there has been a decrease in the admission of general paralysis, congenital insanity,

epileptic insanity, and especially in puerperal insanity, while in senile insanity (above 70) there has been a marked increase.

The death-rate from age is increased from general paralysis, but from phthisis slightly lessened. Asylum-caused phthisis is, he believed, diminishing.

Dr. Campbell concluded by expressing doubt as to a change of type in insanity and his belief in progress in curative treatment; he advocated the desirability of smaller asylums combining to employ a skilled pathologist, with a suitable laboratory, and suggested collective investigation by the Superintendents of Asylums through their Annual Reports.

A vote of thanks for the address was carried by acclamation.

THE CERTIFICATION OF INSANITY.

This discussion was opened by Dr. RAYNER, who dwelt on the obloquy that had been thrown on the profession in connection with the performance of this function and the disadvantages often entailed by it.

The ethical side of certification was also alluded to.

The delay in treatment, caused by the present Legislative Enactments, the popular prejudice against legal certification and the difficulties of certification in certain cases, was dwelt on at some length.

The danger arising from these causes leading to avoidance of certification, by placing patients under conditions of imperfect control, in unsuitable houses and under unskilled persons, was also pointed out.

Suggestions were made that for the poorer classes, reception houses or hospitals were needed similar to those established by Dr. Manning in Australia, and that for the well-to-do a mode of placing patients under recognised treatment for a short period, without actual certification, as permitted by the Scottish law.

The PRESIDENT agreed with Dr. Rayner that it was much easier to find fault with the present system than to suggest a remedy. A great many of the remarks made applied more strongly to the rich than to the poor. The facility for sending a pauper lunatic into an asylum in England was at present quite great enough.

Dr. A. R. TURNBULL supported the existing procedure of certification. He pointed out that in Scotland the emergency procedure is simple, consisting of a medical certificate that the case is one of emergency, and a special request signed by the acting relative, or for a pauper case by the inspector of poor, which asks that the patient be received into the asylum. A very wide meaning is often read into the word "emergency," and it is in fact used where it is simply more convenient to have the papers completed after the patient's removal to the asylum. It allows asylum detention for three days on the certificate of only one medical man. It is conceivable that the second medical examiner might not agree in regarding the case as insane, and needing asylum care. But this seldom if ever happens, and otherwise the emergency procedure does not involve any risk to the patient of unnecessary detention, more than might possibly occur under the permanent procedure.

Dr. T. OUTTERSON WOOD said that he was desirous of bringing forward the question of placing cases under care and treatment without difficulty. Could not some scheme be devised for early treatment in doubtful cases, so that all the benefit would be procured for the patient minus the certificates, and the stigma which undoubtedly attaches to them? He thought it should be possible for the patient whose insanity is doubtful to be placed under care and treatment on the application, by a relative or a friend, to a magistrate (such application to be accompanied by a written medical opinion), for a judicial order empowering the detention of the patient for a special time. Thus in very many cases certificates would be altogether avoided by the recovery of the patient. In such period of observation doubtful cases would be cleared up by the development of the disease, and certificates when unavoidable would be procured without difficulty. Probably some such scheme would be of great advantage in the case of habitual drunkards.

Dr. YELLOWLEES said that in Scotland they had had for years the very provision that Dr. Rayner and Dr. Wood had desiderated, and they valued it highly. On the strength of a certificate by a medical man giving a simple expression of opinion that a mentally affected person would be benefited by such treatment and care, the patient could be sent to a private house for a period of six

months, and there treated and cared for without any stigma of legal certification, and without his name being put upon any legal register whatever. As far as he knew the system had never been abused. He did not think, however, that it could be applied to habitual drunkards. They would rebel. Nor would it apply to all cases of insanity, but as far as it went it was very valuable. He thought it was a very clumsy piece of legislation that required the patients in English asylums to be re-certified at stated periods.

Dr. NORMAN KERR corroborated the statement of Dr. Yellowlees as to the value of the provisions of the Scottish lunacy law for putting alleged lunatics under medical care for a time without certification, but there was a large class of cases which were not covered by this provision, so that some further provision was needed as a probationary term of curative treatment with skilled scientific care and attendance.

The PRESIDENT remarked that a part of the Scottish lunacy law relating to certification had been incorporated into the English law, but with certain important changes which made it very awkward in its operation.

Dr. McDOWALL remarked that the recertification of patients in asylums was really not so irksome as had been represented. He found it useful in many instances.

Dr. M. D. MACLEOD said that as a supplement to Dr. McDowall's remarks he might say, speaking as the greatest sufferer under this Act (for in the first set-off he had dropped 129 patients), that under a proper system of registration the re-certification was an easy routine, and the reviewing of cases in a systematic manner from time to time was distinctly beneficial.

Dr. RAYNER in reply remarked that the observations made had supported the views that he had enunciated. With regard to private patients the Scottish procedure covered the ground completely and exactly. He thought that the discussion had shown that there was really a feeling that something more was needed in their procedure in England with regard to incipient insanity, and he therefore moved:—"That the Section of Psychology recommend that the Council of the British Medical Association should consider the desirability of obtaining for England and Wales some provision for the temporary care of incipient and non-confirmed insanity, similar to that which exists in the Scottish Lunacy Acts."

This resolution was unanimously agreed to.

"The Treatment of Mental and Nervous Diseases by Animal Extracts," by Dr. ALEXANDER ROBERTSON, and "A Note on the Thyroid Treatment of Insanity," by W. F. FARQUHARSON, M.B.

These papers, with the consequent discussion, will, we trust, be printed in the January number of this Journal.

Judicial Evolution in the Responsibility of Delirium Tremens. By Dr. NORMAN KERR, F.L.S., London.

It having been publicly stated that little regard need be paid to a recent isolated judicial charge laying down the criminal irresponsibility of delirium tremens, Dr. Norman Kerr thought it advisable to trace the gradual evolution of this newer, more humane, and juster legal view of accountability in this malady. The Scotch Lord Deas, in 1867, allowed a plea of delirium tremens in reduction of a charge of "murder" to "culpable homicide," and of another similar charge to "manslaughter," there having been mental aberration short of legally-proved insanity. A like reduction had been frequently allowed by several Scotch judges since. Indeed, in 1889, Lord Young declined to let the case go to a jury, and discharged the prisoner (accused of "culpable homicide"), a married woman who, when in delirium tremens, caused the death of her infant child from neglect and starvation, on the ground that delirium tremens was a disease. Apart from mere reduction of the alleged crime, even weak medical evidence of the presence of delirium tremens was accepted as a complete answer by a jury in 1845, *Reg. v. Watson* (York Winter Assizes), and also in *Reg. v. Simpson* (Appleby Summer

Assizes). In 1865 this plea was accepted in the case of *Reg. v. Burns* (Liverpool Summer Assizes), Baron Bramwell ruling that, though the quality of the act might be known, the jury might acquit the prisoner if they believed he was suffering from a delusion leading him to suppose that which, if true, would have justified the act. A similar acquittal as insane, *Reg. v. Chaplin* (Warwick Assizes, November) took place in 1878, the deliriate having been charged with feloniously wounding two persons, who, he supposed, had been breaking into his house.

In 1881 (*Reg. v. Davis*, Newcastle, April 27th) a verdict of "not guilty" was returned, on the ruling of Mr. Justice Stephen that delirium tremens was a distinct disease, the secondary consequence of drinking. The *Digest* and *Brett* both hold that the insanity of delirium tremens would excuse a man, though voluntarily induced. In 1886 Mr. Justice Day (*Reg. v. Baines*, Leicester Assizes, January) charged that if a man was in such a state of intoxication that he did not know the nature of his act, he was insane in the eye of the law, and that it was immaterial whether the mental derangement then resulting from such intoxication was permanent or temporary. In 1895 Mr. Justice Hawkins ruled that delirium tremens absolved from responsibility. Lord James (1892) laid down that if the delirium tremens has become chronic in its effects, or so advanced as to cause insanity, "it would be scant justice to ignore it on account of the cause which has produced it." So much for major crimes. In minor offences this plea had also been allowed, since Lord Deas received it in a charge of theft about a quarter of a century ago; and in 1888 (Liverpool Summer Assizes) a lady labouring under the effects of delirium tremens, who had stolen a purse, a knife, a diamond ring, and 3s., was acquitted. Of recent years the number of minor charges in which this view had been taken had greatly increased.

Hæmatoma Auris. By W. F. ROBERTSON, M.D., Pathologist, Royal Asylum, Morningside, Edinburgh.

Dr. W. F. ROBERTSON gave a microscopic demonstration upon the pathology of hæmatoma auris. The sections illustrated the various stages of the degenerative lesion in the ear cartilage, which, as had already been contended by Fischer, Pareidt, and others, prepared the way for the occurrence of the hæmorrhage. Typically this took place from new vessels in the wall of an intra-cartilaginous cyst. It was shown that these vessels were specially prone to a degenerative change, which must render them liable to rupture from slight violence, or even spontaneously. The blood was slowly effused into the cyst, which tended gradually to enlarge by separation of the perichondrium. Sections of recent othæmatomas were also shown, illustrating the way in which the blood was effused, and the subsequent changes that occurred in it. A full account of the investigation, together with a review of the previous work on the subject, was published in the *Edinburgh Hospital Reports*, Vol. iv.

The PRESIDENT remarked that cases of hæmatoma auris were now more rare than they used to be.

Dr. CLOUSTON said that it was easy to understand that these degenerated areas in the ear-cartilage might set up a hæmatoma without the aid of anything that could fairly be called traumatism. In such cases ordinary acts of mental nursing might be sufficient to bring out the actual hæmatoma.

A Discussion on the General Paralytic; his Practical Management and Treatment in Asylums. Introduced by the PRESIDENT.

The PRESIDENT explained that the intended introducer of this subject had been prevented from being present, and after consultation with one of the Secretaries he had thought it best just to mention this to the Section, and himself to launch the subject briefly, trusting that with such an audience experienced utterances on all points which touched on the matter would flow from many quarters. Some extremely lucky members of their specialty saw little of this fatal and troublesome disease. Others saw a vast proportion. He expected to hear from some of

those present their views as to the increase of general paralysis as a disease. Probably some members might say that general paralysis was several diseases, but they were still dealing with a class of cases which they recognised by this name. He thought that the points which they should keep before them for discussion were the following chiefly, but he hoped speakers would touch on all that occurred to them:—1. How best to treat a general paralytic during his initial excitement, so as to prevent accidents and osseous fractures. 2. During his quiet stages how is he best kept of cleanly habits? 3. Should he at this stage be specially dieted so that he may not become too fat and unwieldy when he gets to the bedridden stage? 4. What are the best sedatives to be used during the course of his disease to keep him manageable? 5. Seclusion. Should it not be used whenever it is necessary for safety in this disease? 6. The bedridden stage. How best to prevent bedsores.

Dr. M. D. MACLEOD said that in order to give an opening to the discussion he might state that in his opinion there were no general lines which could be laid down for the treatment of a general paralytic. With regard to the alleged increase of the disease, he was inclined to think that he saw fewer cases than he used to see. Seclusion was not only beneficial, but absolutely necessary. In his experience no sedative was of any benefit.

Dr. RAYNER thought that overfeeding and the giving of narcotics were often very harmful in general paralysis.

Dr. CLOUSTON said that in the early stage he was now in the habit, in specially acute and risky cases, of combining seclusion with sulphonal. He gave the sulphonal in from 30 to 40-grain doses dissolved in hot milk, a method of administration which a German experimentalist had found to entirely prevent hæmatoporphyrinuria. After the first day the patient became sulphonal-drunk. About the third day a condition a little short of sulphonal coma was produced, and then he diminished the dose. After a week or ten days of this treatment the general paralytic passed quietly and without accident into the second stage of the disease. He had tried this plan in several cases, and, looking to the incurability of general paralysis, he believed that it was one that they were justified on medical grounds in adopting in a certain carefully selected number of instances. If the case did not seem to justify this method of treatment he thought the next best thing to do was to put the early general paralytic in charge of one of their best attendants, to isolate him as far as possible from other patients, and to feed him on a non-stimulating diet. There were some cases in which the motor energy was best expended in work. At the present day there was perhaps too much tendency to think of the prevention of accidents, such as broken ribs in cases of general paralysis, to the exclusion of a large general and scientific view of the disease. With regard to the third stage of general paralysis, he had never himself been unduly proud of the absence of bedsores. He did not think that they were justified in wearing out the patient by subjecting him to too frequent turning, drying, etc. He did not believe that even the most skilful nursing could always prevent bedsores, though they all knew that it could to a large extent diminish them. The trophic condition of the general paralytic was frequently so bad that bedsores would often arise without the influence of pressure at all. Turning over such patients meant a great deal of fatigue to them and their end was hastened thereby. In his experience general paralysis was certainly increasing. Within the last five years the number of cases of the disease admitted to the pauper department at Morningside had been doubled in proportion to the admissions. But he did not see so many of the old classical type of general paralytics. Looking to the known causes of general paralysis he believed that its increase was the result of over-exciting living, especially in cities, and he did not believe in the syphilitic origin of the disease, though he admitted that there were facts which might point that way. The Vienna School of Psychiatry seemed lately to have committed itself to the syphilitic etiology of general paralysis, regarding it in fact as a "Spätform" of syphilis.

Dr. MICKLE described the method of treatment for the excitement of early general paralysis which he preferred, including dieting, purgation, bathing, cold to head; and also seclusion for the worst cases; as well as the use of some of the iodides and bromides. The prevention of fractures or injuries was thus best effected; and

this object in some cases could only be secured by *prolongation* of the plan of treatment proposed; or of such plan of treatment as might be adopted. Bedsores were in some few cases absolutely unpreventable, and a case in proof of this was detailed at some length.

Dr. McDOWALL (Morpeth) said he thought general paralysis had distinctly increased in Northumberland, especially among men.

Dr. A. R. TURNBULL (Cupar) said that there certainly appeared to be an increase in the number of general paralytics, probably from a greater readiness nowadays to send into asylums cases of the quiet type who formerly would have been treated at home. For cases in the third stage he used a mattress in three sections, in the centre of which there was placed a small water-cushion and a tube for draining away the urine. Turning the patient was thus rendered unnecessary. He had found that bedsores which would not heal when the patient was on an ordinary mattress, often closed when an apparatus of this kind was resorted to.

Dr. SEYMOUR TUKE said that in the South there had certainly been a change of type in general paralysis. Whether education had to be considered as a point in this change, and especially in the change of type of delusion, had to be further considered. Dr. Clouston's remarks on sulphonal and treatment were exceedingly interesting, but to say the least the cases would have to be carefully selected. There was another side to the bed sore question, for unless preventive measures were taken, a condition necessitating just as much moving about would come to exist, for the bed sore had to be treated.

Dr. A. CAMPBELL CLARK said that Dr. Clouston's plan of treating early cases was an attempt to push the patient through the first stage as quickly as possible, and this involved a certain amount of risk. He had not been able to confirm Dr. Bevan Lewis's views upon the prognosis of duration, especially with regard to the pupil symptoms. In his experience only a very small proportion of general paralysis could be attributed to syphilis. Bedsores should be prevented because they produced a most insanitary condition in the hospital, from the surgical point of view.

Dr. YELLOWLEES expressed his distinct disapproval of Dr. Clouston's method of treating the first stage. Bedsores ought not to occur if they could be prevented. He agreed with Dr. Mickle that trophic changes sometimes caused bedsores in spite of every precaution.

Dr. CLOUSTON thought that he must have expressed his views as to the sulphonal treatment of general paralysis so as to be misunderstood. As a matter of fact he had only used it in that way in about three cases within the last five years. They were extremely bad cases, cases in which one was driven to extremities.

The PRESIDENT said he agreed with Dr. Mickle that it was sometimes impossible to prevent bedsores. He had seen a general paralytic take thirty epileptic fits and have bedsores all over him within twenty-four hours. He used dusting with tannic acid to prevent bedsores.

The Hospital Movement in Scottish Asylums. By Dr. MACPHERSON (see page 778).

The Hospital Treatment of the Insane in Asylums. By T. E. K. STANSFIELD, M.B., Senior Assistant Medical Officer, London County Lunatic Asylum, Claybury.

Attention was drawn to the harm that may sometimes be inflicted upon recent recoverable cases by the massing together in a large building all sorts and conditions of patients, and the difficulty of sufficiently focussing attention on these presumably recoverable cases. The desirability of much earlier treatment of mental cases was insisted upon. To aid this, he suggested the establishment of central receiving hospitals (if connected with a general hospital and medical school, so much the better), with an experienced staff, where patients might be received for short probationary periods, on the recommendation of medical practitioners, and there be closely observed. The stigma of going to an asylum would in some instances thus be avoided; the remainder would be transferred to the asylum, but

yet would have been under close medical observation throughout. He laid stress on the fact that, in dealing with the insane, there were two classes to care for, the recent, recoverable or "hospital" class, and the chronic or "workhouse" class; in other words, that an institution for the insane pauper class should be a combination of a general hospital and a workhouse. The hospital portion of the institution, he would have centrally placed and connected with the administrative department; it should have all the appurtenances of a general hospital; the wards should be of small size, with a larger proportion of side rooms than was usually now provided, and these should be arranged so as to minimise noise. The accommodation of this part of the building should be two-fifths of the anticipated yearly admission rate; the staff should be thoroughly trained, with every possible means for modern treatment and research. For the other sections of the institution where the chronic insane are to be nursed, he would suggest a trial of the cottage system.

Dr. GEORGE M. ROBERTSON said that at Murthly the convalescent department consisted of a detached house, to which the patients were drafted as they improved, and the benefits of such a place had been more than one could believe. This house had no asylum or hospital features, it was highly decorated, better furnished than asylum wards had been in the past, and it had a special name. Patients in such a detached house felt as if they were not in the asylum, their self-respect rose, and they cast off their asylum habits and assumed their natural ways.

Dr. URQUHART referred to the difference of opinion as to the cases proper for treatment in asylum hospital sections, whether all recent admissions should be admitted and so on. He would particularly say that each physician must develop the institution under his care on the lines most suitable in the special circumstances of each case. As one who had built a special hospital, nearly ten years' experience had approved the departure then made at the Perth Royal Asylum. With regard to the cottage or villa system, that had long since been firmly established as eminently desirable.

Dr. CLOUSTON said he admitted to his hospital not merely bodily sick cases, but all very weak melancholiacs, all puerperal and lactational cases, and all cases where bodily nursing was, as it were, the key-note of treatment.

Dr. YELLOWLEES said that the whole asylum was a hospital, or things were wrong altogether. What they really wanted was that the hospital spirit should pervade the institution.

Dr. S. R. MACPHAIL asked if Dr. Macpherson could recommend them to adopt female nursing in the male wards of asylum hospitals.

Dr. A. CAMPBELL CLARK said he thought it was not convenient to have special wards for special kinds of cases in asylum hospitals. The cases requiring hospital treatment did not usually classify themselves in the way anticipated.

Dr. A. R. TURNBULL said that, at Montrose, Dr. Howden intended his hospital building for cases of bodily illness, and still received his newly admitted patients in a ward of the old building. At Larbert, Dr. Macpherson received all his admissions into the hospital building, while he had a subsidiary sickroom in the old building for cases of bodily illness occurring among the chronic patients. The recent admissions and the cases of bodily illness occurring among either the new or the chronic patients were now received into a new hospital building at Fife, but into separate sections or wards of it, thus combining to some extent the ideas followed out separately at Montrose and Larbert. Ready communication between the different buildings, so as to facilitate the removal of patients from one part of the asylum to another was a great advantage; it moreover allowed of structural arrangements by which female nursing could be utilised more or less on the male side. In the Fife Asylum the male sickroom was staffed entirely by female nurses. His experience of this arrangement was exceedingly favourable.

Dr. URQUHART asked for information as to the cost of these hospitals.

Dr. MACPHERSON, in replying, said that he employed three female nurses in his male hospital. Regarding the cost it was under two hundred pounds per bed, but that could not be legitimately compared with the lesser cost incurred in erecting separate houses for the purposes described at Murthly.

A Discussion on the Use of Sedatives and Hypnotics in the Treatment of Insanity.
Introduced by L. R. OSWALD, M.B., Medical Superintendent, Gartloch Asylum, Glasgow.

In opening the discussion on the use of sedatives and hypnotics in the treatment of insanity, Dr. OSWALD commented on the very different views held by alienists as to their usefulness, and on the degree and frequency with which they were prescribed in different asylums. He believed that a drug-induced sleep was often bought at too high a price, and he regretted that in the construction of asylums more attention was not paid to specially arranged rooms where all the external causes of sleeplessness would be minimised. He regarded indication of failure of strength as the chief symptom making urgent the procuring of rest in acute cases, and laid special stress on the necessity for making sure that the absence of sleep was not due to some peripheral irritation. Taking acute cases generally his experience led him to prefer sulphonal. It had few bad effects, and it tended to restore the broken sleep-habit. It had a slightly diuretic action as well, and it did not depress. He had given it hypodermically in two cases without local inflammation following. It was unfortunate that in the rush for new drugs so many of the older sedatives and hypnotics had been forgotten. How often was conium juice prescribed now, and was digitalis as often used as its calmative power undoubtedly deserved? He believed it was one of the dangers to guard against, namely, that of falling into the habit of using one or two sedatives to the exclusion of others. Chloral especially, when combined with one of the bromides, was most useful as a day sedative, a term to which he took exception. It might not be so effectual as sulphonal, but its bad effects were fewer. The bromides, combined with cannabis indica or hyoscyamus, could be pushed to much larger doses than were generally given, and were powerfully sedative. Sulphonal he used as seldom as possible, believing that its action was accompanied in many cases by a destruction of the red-blood corpuscles. The belief that its administration produced a mild dementia was a growing one. Its value in chronic mania was undoubted, but its use tended to mind weakening. It cut short periods of excitement, but the patient did not regain mental clearness. Morphia was not so useful as opium, and his experience of hyoscyne and hyoscyamine was not favourable. He confessed he had failed to come, in a very limited experience, to any definite conclusion regarding the use of these drugs. Useful they were, but not nearly so essential to the treatment of patients in an insane hospital as many supposed. A diminution in the frequency with which they were prescribed would lead to the development of other means for treating the symptoms for which they were given. They were not the best hypnotics and sedatives. These were found in exercise, work, distraction of thoughts, amusement, and the like, but the scope of the discussion did not include these. In the treatment of the insane in private houses their use could often not be avoided, and if they did—as he believed—in many cases retard recovery, he saw in that a strong argument for the treatment of mental diseases in asylums. In asylums when they had to be used he preferred a pure hypnotic like paraldehyde or alcohol, and in other cases chloral with bromide, or bromide with cannabis indica. Sulphonal he never gave without feeling that he might be setting up a morbid condition over which he would have little control.

The PRESIDENT said that, regarding the curative influence of hypnotics and sedatives in insanity, he thought they had none. He was certain that the continuous use of such drugs for any length of time had a tendency to retard recovery.

Mr. M. D. MACLEOD said sulphonal had a distinct appetising effect. He never saw any real harm result from a proper use of sulphonal. It usually did harm in cases of folie circulaire. It might shorten the excitement, but it prolonged the depression and clouded the quiescent period. He used fewer drugs of that class than he used to do. The most efficient hypnotic he had found was a solution known as bromidia. He had used no preparation of opium as a sedative, only as an anodyne. Hyoscyamine was occasionally of use, and in moderate doses allayed the restlessness of certain organic cases, such as those of brain tumour, more effectually than any other drug.

Dr. YELLOWLEES said that they as yet knew very little about the action of hypnotics and sedatives, and consequently they were very often working in the dark in using them. If he were to sum up his convictions about their employment in insanity he would say "the less the better." There should be a definite distinction drawn between the extent to which such drugs were given in incurable cases, and in cases in which there was a reason to believe that recovery might take place. They should put up with a great deal from a curable patient before they ran the risk of the brain-cell injury which these drugs were so apt to inflict. They always retarded, and sometimes even prevented recovery.

Dr. McDOWALL said that he used to give hypnotics very freely, but now he employed them very rarely indeed. He still used them extensively in one class of cases, however, viz., melancholia. He had been told by patients that physicians did not properly understand the great misery of sleeplessness. To diminish this he gave his melancholiacs chloral, sulphonal, or other hypnotics. He never used such drugs in cases of mental excitement. He practically never gave morphia or hyoscine.

Dr. J. CARLYLE JOHNSTONE said that in prescribing sedatives and hypnotics in the treatment of insanity he would act upon the same general principles as those which would guide him in treating other diseases. If recovery was not being promoted under their use, if the patient could not be said to be better than he was before, he would say that, even although sleep and quietness had been produced, they had failed in their purpose.

Professor GAIRDNER said there was one disease which could hardly be looked upon except as a form of insanity, in which he had had some experience of hypnotics, viz., delirium tremens. He remembered the time when the administration of opium and stimulants in high doses was the orthodox treatment. He believed that in that way they simply poisoned the patient, and he concluded now that no narcotic whatever should be given in this disease. Dr. Oswald had spoken of the action of sulphonal in destroying the red-blood corpuscles. It was of the highest importance that they should be on their guard against the secondary actions of such drugs, for they were often very injurious.

Dr. A. R. TURNBULL said he thought these drugs were very useful in tiding over an emergency. He had found sulphonal most useful, and he had never seen any ill effects from it.

Dr. DOUGLAS said that the most valuable use of hypnotics was to be found in that period which preceded the state in which a patient could be certified. They could often tide over a crisis at such a time by means of drugs. He had found croton chloral and bromides of the greatest value. He also recommended tetronal in ten-grain doses as a hypnotic.

Dr. OSWALD, in replying, said that from his own point of view he would prefer if possible always to do without hypnotics. He thought that in the future much more was to be done to combat sleeplessness by other means than that of drugs.

The Modes of Provision for the Chronic Pauper Insane. By A. R. TURNBULL, M.B.Edin., Medical Superintendent, Fife and Kinross District Asylum, Cupar.

The modes of providing for the chronic pauper insane may be classed under two heads :—(1) Institutional Care, comprising (a) Asylums and (b) Wards for Lunatic Patients in Workhouses or Poorhouses, and (2) Private Care. After referring to the practice in different countries, Dr. TURNBULL said that the lunacy legislation already established, the density of population, and other social conditions, make it practically certain that in this country the great proportion of our insane cases must always be provided for in institutions; but it is deserving of inquiry whether the system of private care could not be developed and utilised to a greater extent than at present. It has been followed in Scotland for many years, and provides in a satisfactory way for more than 20 per cent. of the total number of cases on the official registers. The patients suitable for this care are those who are not dangerous to themselves or others, and not offensive to

public decency or amenity. Those suffering from the less severe forms of congenital defect, from moderate dementia, or from mildly delusional forms of mental derangement, come often into this class. Patients labouring under more severe forms of insanity or under organic disease of the brain have sometimes been placed in private care; and in Berlin the system is also followed to secure the removal from the asylum for a limited time of cases of remittent or periodic insanity; but in these conditions all the circumstances of the patient and of the guardianship should be very carefully considered. The objections to the system are the difficulty of finding guardians, and the risk that the guardianship provided may be inefficient. Experience in Scotland and elsewhere has shown that suitable guardians can be got in greater number than might at first be expected; and the risk of inefficient guardianship is minimised when the patients are under careful and regular inspection by responsible authorities. Central supervision and control by a General Board of Lunacy or corresponding authority is essential for the success of the system. In Scotland objection has also been made to the aggregation of relatively large numbers of patients within a limited district, and this should be guarded against, both for the sake of public amenity and because it is contrary to the interests of the patients themselves. In regard to institutional care, the lunatic wards of workhouses or poorhouses are meant to receive only cases in which the hope of ultimate recovery has been given up. They take the place so far of the chronic wards of the asylum, and in this way they lighten the dead weight of chronic lunacy which would otherwise gather in the latter, and leave it free to deal more readily with the more severe and more helpless forms of insanity. Under our present system it is perhaps neither desirable nor possible to forego the accommodation supplied by the workhouses and poorhouses. But it is probable that a proportion of the cases kept there could be provided for suitably under private care, if the latter were developed, and it is also questionable if it is expedient to place the care of any section of the lunatic poor with the authorities charged with the administration of relief to the ordinary poor, because the lines of work are necessarily very different in the two cases. Those patients who are not suitable for private care would probably be maintained as efficiently and as economically in the asylum as in the workhouse; but there is the great objection that this would add considerably to the size of our asylums, many of which are already much over-grown. The remedy for this would be to subdivide the lunacy districts sufficiently, so that the asylums would be more numerous, but more moderate in size, with a smaller annual number of admissions and a smaller burden of chronic lunacy in each—a change which would probably be beneficial both for the patients and for the institutions. In this view it would be desirable that no asylum should have more than 1,000 patients, and perhaps the number might with advantage be restricted considerably below that figure.

The PRESIDENT said that there were one or two commonly accepted beliefs about this subject that were capable of correction. Dr. Turnbull had almost hinted that there was no proper inspection in England. But there was a power of inspection, whether it was carried out or not. The Commissioners in Lunacy were now exactly the same in number as when the Board was constituted. These six officials inspected over 90,000 lunatics each year. He thought that the amount of work that the English Commissioners did was not properly realised. It was to be remembered that the Scots had the benefit of the working of the English Lunacy Act for ten years before theirs was drawn up, and they had the advice of two of the English Commissioners. The boarding-out system had really been begun in England by Sir J. C. Bucknill, and not in Scotland. It would certainly be an advantage if the advice of the asylum physician was taken about patients who were boarded out.

Dr. URQUHART said that he thought the boarding-out system of Scotland was most valuable. He disagreed with Dr. Sibbald when he said that medical officers of asylums were not specially suited to superintend patients in private dwellings. Such a dictum was a wrong to the physicians of their specialty. They ought to be the centre of the lunacy administration in the district in which their work lay. They ought to have the power to place their patients in the positions that they thought best, and should not lose interest in them because no longer actually in

the asylum. His opinion was that this Association should take up the question of the number of the Lunacy Commissioners in England, and urge upon the Government that it should be increased. It was absurd to suppose that the same number of men as were required when the Commission was constituted could now overtake the work as efficiently.

Dr. CUMING (Belfast) said he believed that the relation between asylums and workhouses was unsatisfactory; he hoped the section would give as much light as possible on the subject of what class of cases could be justifiably transferred to Union hospitals.

Dr. CARLYLE JOHNSTONE also considered that boarded-out patients should be under the supervision of the Asylum Superintendent of the district.

Dr. GEORGE M. ROBERTSON said that the majority of cases that were sent out were those whom the Superintendent felt certain did not need daily inspection by a skilled alienist, but who simply required ordinary home comforts.

Dr. TURNBULL, in replying, said that he did not at all mean that the English Commissioners were slack in their work, but he thought that more of them should be appointed, and that the boarding-out system should be adopted. The service of the asylum medical officer should be utilised for the boarded-out patients. He agreed with Dr. Cuming that the workhouse was not the place to send patients to from the asylum.

Abstracts of papers and discussions on "Morbid Shyness," by Dr. H. Campbell; "Insanity in Children," by W. Ireland, M.D.; on "Mental Strain in Education," by G. E. Shuttleworth, M.D.; and on "Post Influenza Insanity," by Dr. Rutherford Macphail, are postponed to the January number.

PATHOLOGICAL EXHIBIT.

Dr. R. W. Philip (Edinburgh) showed a preparation of brain in the Annual Museum, which was of interest as having been taken from a case of hemiplegia with aphasia following on pulmonary phthisis. The most careful examination, with naked eye and microscope, failed to discover any pathological change. Dr. Philip has described this rare case in the fourth volume of the *Edinburgh Hospital Reports*, to which reference should be made. Some slight degree of engorgement of the veins on the surface of the brain and a trifling degree of softening of the left hemisphere were noted, but it is apparent from Dr. Philip's statement that there was no cerebral lesion in the ordinary sense.

RECENT MEDICO-LEGAL CASES.

REPORTED BY DR. MERCIER.

Reg. v. Allen.

Herbert E. Allen, 23, barman, was indicted for the wilful murder of Henry James Skinner. Deceased was manager of a Bodega in which prisoner was employed. The deceased, who had been a kind master, had occasion to discharge the prisoner. Two days after, the prisoner called at the Bodega, and, with a revolver, shot Skinner dead.

It was proved that the prisoner's father had attempted suicide; that a brother at the age of fifteen had committed suicide; that a second brother had attempted suicide; that the prisoner had had, about six months before the crime, a fall from a tree, by which his jaw was broken, and that since this accident his disposition had been changed. Before it, he had been kindly disposed and would do anything for anyone. Since, he had been of a sullen disposition, gloomy, irritable, and depressed. He would fly in a passion for no earthly reason, and when in a passion seemed to lose control of himself. Several of his associates considered after the accident that he was "going daft," and was not responsible for his actions. He suffered since the accident from intense pain in the head, and optic neuritis.

Dr. Whitcombe, Medical Superintendent of the Winson Green Asylum, called by the defence, deposed that he examined the prisoner on behalf of the Crown on five different dates. "I found the prisoner intelligent and of good memory, and apparently unreserved. . . . His conversation was lucid and collected, and

there was no effort at simulation. At the same time I found a great disposition to disregard his own life and to look upon the act he had committed with levity." . . . Do you form any opinion upon the evidence given here to-day?—I formed the opinion previously that the prisoner at the time this act was committed was conscious of the act, but that at that time he was suffering from brain disease, which would have the effect of weakening his mental powers, and that that disorder has not yet passed away.—What do you say as to his condition as to suddenly developing definite symptoms of insanity? I think the prisoner is peculiarly liable at any moment to show active symptoms of insanity.—Might that be in the direction of homicide? It might be in any direction—including homicide? Yes.—What do you say as to the hereditary taint in the family? There appears to be a neurotic tendency in the family, and a peculiar tendency to disregard their own lives and to play with firearms. There also appears a disposition to suicide. I think the complaints about the head are consistent with the disease from which he was suffering.—What effect would they have on the prisoner? To weaken his mind.—What do you say as to the tendency to insanity? The tendency to insanity is much increased by the disease.—Judging from his actions would you say he was developing insanity? I think he has shown the early symptoms of insanity.—Previously to the act? Yes, speaking from the general evidence.—Might this act have been the climax of the symptoms? There is nothing about his symptoms that points to such an act developing.—But might it? It might have been, certainly.—Cross-examined: When I examined him I found him a sane man.—Do you think this man when he shot at Skinner knew perfectly well that he was shooting Skinner? Yes.—Prisoner was suffering from inflammation of the membranes of the brain, but not sufficient to obscure the knowledge of what he was doing.

The Judge directed the jury that the question for them was a very simple one. Did the prisoner know what he was doing when he shot Skinner, and did he know that it was wrong to do it? He then paid a very high compliment to Dr. Whitcombe, and wished that other doctors who had to give evidence in such cases would acquire as much knowledge of the law. (Dr. Whitcombe had asked for and received permission to read in Court the notes that he made when examining the prisoner on behalf of the Crown. A part of these notes consisted of statements with regard to the crime made by the prisoner. These statements Dr. Whitcombe refrained from reading, at the same time handing the notes to the Judge in explanation of his omission. It was this course on the part of the witness that was so warmly commended by the judge.) If the jury thought that the prisoner knew what he was doing when he shot Skinner, they must find him guilty; but if, on the other hand, they thought that he was not capable of appreciating the consequences of his act, they would acquit him.—The jury having consulted for forty minutes returned into Court and asked to have the evidence of Dr. Whitcombe read over to them. Eventually they found the prisoner guilty but strongly recommended him to mercy. On being asked in the usual form if he had anything to say, the prisoner read a remarkable statement to the effect that as long as he could remember he had always, whenever a misfortune befell him, turned his thoughts instantly to suicide; that he had several times attempted suicide; that in taking the life of a fellow creature his intention from the first had been self-murder; that it had been only the hope and the certainty that he would be condemned to death which had prevented him from committing suicide while in prison. "I have tried," said he, "other ways to get rid of myself, but that does not matter now, as you are going to do it for me, and I am very pleased that I shall not commit suicide after all. I . . . trust no one will petition the Government for a reprieve for me, as I should only strangle myself the first opportunity if you obtained one.—Birmingham Assizes, March 16 (Mr. Justice Grantham).—*Birmingham Daily Post*, March 17, 1896.

The criminal was clearly a man of morbid mind. He inherited a strong

tendency to suicide, and the effect of the fall had been to produce organic disease of the brain, or its membranes, or both. His companions had considered before the crime that he was "going daft," and one of them had actually told him that he was mad. The motive for the crime, as stated by himself, was the same as in the case of Hadfield, who was acquitted on the ground of insanity. The whole circumstances of the case take it out of the category of ordinary criminality, and show that the crime was committed by a man of morbid mind, and was in part the direct result of the morbidity of mind from which he suffered. Why was he not then found insane? Was the verdict due to the terms in which the issue was left to the jury? The jury were told that if the prisoner knew what he was doing when he shot Skinner, and that he was doing wrong, they must return a verdict of guilty; and the evidence of the medical expert was, "I think he knew he was shooting him." It does not appear that any evidence was given that the prisoner knew that he was doing wrong, but this is, of course, presumed until the contrary is proved, and there was no evidence at all to the contrary. It appears therefore on the face of it that this man of morbid mind was convicted of a crime that was due to the morbid state of his mind, and that the conviction was due to the terms in which the issue was left to the jury. There now arises the further question: Ought he to have been convicted? Was the disorder of his mind, which unquestionably did exist, such as would, and did, render him irresponsible for the act? The expert evidence was that he was suffering from brain disease, which would have the effect of weakening his mental powers, and that he had shown early symptoms of insanity. But on the other hand, when Dr. Whitcombe was asked "Did you find him a sane or an insane man?" he was obliged to reply "A sane man." And after this answer the jury had surely no alternative but to convict him, whatever the precise terms in which the issue might have been left to them. This point is very important, for it has been alleged that insane prisoners are sometimes convicted because the expert evidence is that they know what they are doing and know right from wrong, and that the expert is not given the opportunity of stating whether the prisoner is insane. If indeed the issue had been left to the jury in terms that have been suggested, viz.:—Was the prisoner of unsound mind: and was the act due to his unsoundness of mind? it is possible that the jury might have answered in the affirmative, and it seems certain that in so answering they would have answered rightly. But it is evident that behind the questions that are left to the jury, in whatever terms they are left, is the vital question: Ought he then to be punished for what he did? This is the real question that the jury have to settle, be the terms of the questions left to them what they may, and this question has, in the last resort, to be settled by ascribing the motive by which the act was prompted. In the present instance the motive appears to have been two-fold: (1) The desire for vengeance. (2) The desire to practically commit suicide by being hanged for murder. These motives acted upon a mind that was disordered (*a*) by hereditary instability and (*b*) by cerebral disease. It is evident that the verdict of the jury will be determined by their judgment as to whether the crime was due mainly to the desire for vengeance, or whether it was due to a desire to be killed dominating a mind hereditarily predisposed to suicide, and further disordered by injury and disease of the brain. In short, they had to apportion the relative amounts of sanity and insanity that entered into an action that was partially sane and partially insane. Of the motive of desire for self-destruction they were not aware until after the verdict was given. So to apportion the motives of any human being is a task of the utmost difficulty. The jury, after hearing the evidence, determined, with considerable hesitation, that the sane element preponderated, and they convicted the prisoner. It is possible that with the additional evidence of motive supplied by the prisoner's speech after conviction, they might have come to a different conclusion. It is possible that, with this additional evidence, one or more experts examining the prisoner after conviction, may determine that upon the whole insanity may have preponderated over sanity in actuating the crime and may recommend a

reprieve. But if this should happen it by no means follows that the jury ought, upon the evidence before them, to have come to a different conclusion, or that the prisoner was wrongfully convicted owing to the terms in which the issue was left to the jury.

The prisoner was subsequently reprieved and committed to Broadmoor.

Reg. v. Waterhouse.

The prisoner was charged with wounding Thomas Hall, with intent, &c. Prosecutor sold prisoner a watch, to be paid for in instalments. Payment being due, prisoner wrote to prosecutor appointing to meet him and they met accordingly at a Railway Station. Thence they went to an inn, which being crowded, they adjourned to prisoner's lodgings. They were on good terms, and prosecutor wrote out a receipt, when suddenly prisoner seized him by the forehead, forced him back in his chair and cut his throat. Prisoner then ran away. Insanity was pleaded.

Prisoner's mother deposed that when a child he was kicked in the head by a horse, and had always suffered from headache and dizziness, "and had shown other signs of a diseased mind." Also that her uncle and his son had been confined in a lunatic asylum. It appears that among the "other signs" above mentioned was that of epilepsy, for another witness deposed to prisoner biting his tongue till it bled.

Dr. Chadwick and Dr. Brown, physicians to the Leeds Infirmary, said the symptoms described were those of *petit mal*, the effects of which they described. Prisoner was found guilty but insane.—West Riding Assizes, March 11th.—*Yorkshire Daily Post*, March 12th.

The plea of irresponsibility from *petit mal* is very rarely successful. The result of the above case points to the direction of an enlightened judge, whose name is unfortunately not given in the report.

Reg. v. Baxter.—"The Sefton Murder."

Prisoner, a married woman, was indicted for the murder, on February 17th, of her two children. Prisoner was seen on the afternoon in question running about her garden trying to cut her throat with a razor and crying out "It won't cut." Her two children were found in the house with their throats cut. When arrested she "appeared to be out of her mind." She was not in a fit condition to be charged until next day. In answer to the charge she said "I don't remember it. I must have been mad."

Dr. Fitzpatrick saw the prisoner shortly after the crime. When he spoke to her she said "It won't cut; it won't cut." She had nothing in her hand then. She did not recognise witness. He had come to the conclusion that the prisoner was insane at the time the act was committed.

Dr. Wiglesworth said he examined the prisoner on the 3rd March. She was then insane, and he was of opinion that her insanity was such at the time of the murder that it rendered her irresponsible for her actions.

Dr. Beamish, Medical Officer of Walton Prison, had come to the conclusion that the prisoner's conduct was attributable to a deranged state of mind, that she committed the deeds referred to in a paroxysm, and she probably did not know what she was doing.

The Judge said it was quite clear from the evidence that the prisoner did not know what she was doing at the time, and

The jury found the prisoner guilty, but insane.—Liverpool Assizes, March 23rd (Mr. Justice Kennedy).—*Liverpool Daily Post*, March 24th.

When, as in this case, the Judge is satisfied, upon reading the depositions, of the insanity of the prisoner, he allows the utmost latitude to the medical witnesses, McNaghten notwithstanding.

Reg. v. Holland.

Joseph Holland, 27, coachman, was indicted for the wilful murder of Annie Chambers. Deceased took some food to the prisoner, who lodged in her house. Prisoner thereupon struck her on the head with a hammer and cut her throat.—Dr. Bastian, who had examined the prisoner on behalf of the Crown, was called for the defence, and stated that he believed that the prisoner committed the act under the influence of an acute attack of homicidal mania. He thought that the prisoner did not know the nature and quality of the act at the time he committed it.—Dr. Pitcairn gave evidence to the same effect.—The jury found the prisoner guilty, but insane.—Central Criminal Court, February 26th (Mr. Justice Wills).—*Times*, February 27th.

The evidence of the medical experts who had examined the prisoner on the part of the Crown was placed at the disposal of the defence. They were allowed to answer the same questions in the same terms that were put to the jury.

Reg. v. Pett.

George Thomas Pett, 54, retired tradesman, was indicted for the murder of his daughter Lilian, at Brighton. Prisoner took his two children for a walk, took them to the end of the "Banjo" groyne, pushed them into the sea, and jumped in himself. Prisoner and one child were rescued, the other was drowned. Prisoner had left a letter on the groyne addressed to his wife and stating, "I have destroyed the last will, so the former one leaves you all. Life is unendurable; you will find me near the 'Banjo' groyne. Your sorrowful husband." The prisoner made a confession describing what he had done and added that he was very glad the eldest child was dead.—A number of medical and other witnesses were called, who proved that the prisoner was a kind father and husband and a man of means. He had had influenza and since then had suffered from melancholia with suicidal tendencies.—Guilty, but insane.—Lewes Assizes, February (Mr. Justice Wills).—*Times*, February 15th.

It was proved that the prisoner knew the nature and quality of his act, but as usual in such cases in which the evidence of insanity is strong, the prisoner was nevertheless found insane.

Carter v. Dove and others.

Plaintiff applied for probate of a will made on July 1st, 1895, by Mr. Charles Bathurst Woodman, who died on September 28th, 1895. Defendants opposed probate on the usual grounds. The testator was an old man of 87, and had been certified as a lunatic and taken charge of by the plaintiff in his (testator's) own house since September 24th, 1894. It was proved that during the year preceding his death the testator had been filthy in his habits and surroundings; that he was disgustingly indecent; that he was violent; and that he had delusions of poverty.—Dr. Savage testified that he examined the testator on January 12th, 1895, and found him suffering from incurable dementia. He was, in Dr. Savage's opinion, quite incapable of transacting business or of making a will.—Dr. Wallis, Commissioner in Lunacy, examined testator on July 4th and considered that he was not fit at that time to make a will.—Dr. Rayner deposed that the testator suffered from senile dementia.—Various other witnesses related insane conduct on the part of the testator. On the other hand it was shown that the testator had cherished for many years, and long before he became insane, a feeling of enmity and bitterness against the relatives whom he excluded from benefit under his will and who now contested its validity.—The jury found for the will.—Birmingham Assizes (Mr. Justice Mathew).—*Birmingham Daily Gazette*, March 20th, 21st, and 23rd.

An ordinary instance of the difficulty of upsetting a will on the ground of insanity.

(From the official shorthand notes.)

CENTRAL CRIMINAL COURT, MAY 20-22, 1896.

Reg. v. Dyer.

Amelia Elizabeth Dyer, 57, nurse, was indicted before Mr. Justice Hawkins for the wilful murder of Doris Marmon. The prisoner was a baby-farmer on an extensive scale, and the facts were not disputed, she having confessed to many infanticides. The defence relied on her present mental condition, and on the fact that she had previously been under asylum treatment.

For the defence, Dr. Fred. Logan, Bristol, had examined the prisoner in December, 1893. She was very threatening, and offered him personal violence. Said she heard voices telling her to destroy herself, and that the birds said "Do it." Her daughter said she had attempted suicide. On this he certified her insane.

Cross-examined: Had not seen prisoner before or since that occasion. Heard she was shortly after discharged from the asylum. Saw no other symptoms besides those mentioned. Did not use the ophthalmoscope. Saw no evidence of any suicidal attempt. His examination lasted a quarter of an hour, perhaps longer. Considered her conduct was due to disease of the brain and drink. Distress or fear might induce this form of insanity.

Dr. Lacy Firth, Clifton, treated prisoner in May, 1894, while house surgeon at Bristol General Hospital. She was there thirteen days for attempted suicide by drowning. Was very low-spirited, refused food, and said she had something on her mind. She would not say what it was. Did not consider her insane.

Cross-examined: In consequence of inquiries at the hospital he interrogated prisoner as to the loss of a child placed in her charge. She admitted partial knowledge of the affair.

Dr. William Eden, Hambrook, had examined prisoner at Fishponds, Bristol, in December, 1894, on relieving officer's order. She was excited and "bellicose," threatened to pitch him out of the window, said God had forsaken her and the world was against her. Daughter said she had threatened her with a knife and had attempted suicide. Examined her for about ten minutes and signed a lunacy certificate.

Cross-examined: She remained one month in Gloucester Asylum. Saw no traces of attempted suicide about her. She was not depressed; quite the opposite. Daughter said she had been in an asylum.

Dr. Forbes Winslow had examined prisoner for the defence on two occasions in Holloway Prison. Had formed no opinion as to her condition before he saw her. Considered her of unsound mind, suffering from melancholia, with delusions and hallucinations. There was no excitement nor any attempt to feign insanity. Concluded she was not shamming. She volunteered the statement that she often got depressed mentally, that voices spoke to her every night and told her to take her own life, and that she had made several attempts to do it, but had been prevented. Said she was frequently visited by the spirits of her mother and son. Her memory was good for what happened years ago, but bad for recent events. That, with the other symptoms, would show organic disease of the brain. She had no recollection of the crime, and said she became mystified when she tried to recollect it. Could not remember the names of any of the children, had never missed them, and could not tell when she had seen them last. She alluded to terrifying visions, but would not specify them as they were "too horrible." When pressed, said she was accustomed to feel as if she were handing her mother's bones out of her coffin and that rats were crawling all over her. This recurrent form of insanity was the most formidable of its kind.

Cross-examined: Depression in a sane person charged with murder was not unnatural. Prisoner did not mention the voices and visions until he had asked

her if she heard or saw them. Did not expect to find excitement as in melancholia and monomania. There are no outward signs of insanity. People in trouble often conjured up visions and dreams. Should not be surprised either way if they had them or not.

For the prosecution, Dr. James Scott, medical officer of Holloway and Newgate prisons, had had prisoner under his observation since her committal to Holloway on 2nd May. Had seen and conversed with her daily, and had received reports about her from the attendants. Did not consider her insane. She had stated that she was suicidal, and that her memory of recent events was a blank. Had tested her memory and found that it was good as to previous events. She stated she had been an asylum attendant.

Cross-examined: It was possible for a homicidal maniac to be free from excitement. Considered her to be simulating insanity. Was present at her interviews with Dr. Winslow, and considered it would be unsafe to deduce insanity as a result of them. Had never seen any suicidal tendency in her, nor had she behaved in an insane manner.

Dr. G. H. Savage had examined the prisoner at the request of the Treasury. He came to the conclusion she was not mentally unsound. Although she said she did not recollect the crimes, he found all other facts of her life were clear in her memory. A homicidal maniac might hear voices, but they would incite to murder, not to suicide. The circumstances of the children's murders did not in his opinion suggest any homicidal mania.

Cross-examined: Had read of the case before examining prisoner, but was unbiassed in his report as to her sanity. Impulsive insanity was a very formidable variety. The hearing of voices was a symptom of homicidal mania; the voices might command or indicate. Homicidal mania was not usually periodical. Homicidal persons commonly attempted suicide, and did not wish to live. Confession of guilt was not characteristic of it. Understood there was no family history of insanity. Was aware of Dr. Logan's certificate of 1893 and of the symptoms he described, but had no right to deny or question facts relating to years gone by.

Prisoner was found guilty and sentenced to death, being executed June 10th.

(From the official shorthand notes.)

CENTRAL CRIMINAL COURT, JUNE 25, 1896.

Reg. v. Allison.

James Robert Allison, 28, publican, was indicted before Mr. Justice Hawkins for the wilful murder of his wife by shooting. The following medical evidence was produced by the Treasury:—

Dr. H. Charlton Bastian had examined the prisoner, and could find no evidence of insanity at present.

Cross-examined: Homicidal mania was abrupt, sudden, and without apparent motive. A homicidal maniac would not know the nature and quality of his act. It was quite possible the prisoner had an attack of homicidal mania on the occasion of the crime, in which he would be bereft of reason and the power of control.

Re-examined: Considered it possible from the facts of the prisoner's neurotic family history* and from his known intemperate habits, also as prisoner was stated to have been anxious as to his wife's health, also as there was no evidence of an altercation prior to the act, his habits and family history would render him liable to sudden gusts of passion—very near to irresponsibility. A sudden thought would impel him to do the act, and for some time the notion might linger in his mind, which would account for his asking "Have I finished the job? Is she dead?"

Dr. James Scott, Medical Officer of Holloway and Newgate Prisons, had had

* Two brothers were stated to have died by suicide.

the prisoner under observation ever since his arrest. Had been unable to detect any trace of insanity in him. He probably had an exaggerated idea of jealousy as to his wife, which might have been a delusion.

Cross-examined : His examination was of course confined to the prisoner's condition subsequent to the act. Prisoner had not been so anxious as was usual in a person in his position. Agreed with Dr. Bastian that it was possible he had a sudden attack of homicidal mania at the time.

Prisoner was sentenced to death. The Secretary of State subsequently ordered his examination by Dr. Savage and Mr. Brayne, of Broadmoor, and in the result the sentence was commuted to penal servitude for life.

PARLIAMENTARY INTELLIGENCE.

HOUSE OF COMMONS.

Treatment of the Insane in Ireland.

Mr. M'Cartan asked the Irish Secretary whether his attention had been called to the proceedings at an inquest held in Belfast Workhouse into the death of an inmate named Eliza Jane Hanna, in which it appeared that the deceased had been a patient in Belfast Asylum; would he state when and under what statute she was transferred to Belfast Workhouse; whether she belonged to the Belfast Union, and, if not, under what authority did the guardians of the poor there admit her and keep her confined in Belfast Workhouse at the expense of the ratepayers of Belfast; whether Belfast Workhouse had ever been certified by the Inspectors of Lunatics or the Board of Control as a suitable and proper place for the reception of the insane; whether he was aware that the doctor of the workhouse swore at the inquiry that the patient was transferred without any consultation between the doctors of the two institutions, and that the recreation yard at the workhouse was so small and usually so noisy that it had been described by one of the inspectors as a pandemonium; and whether he would have full inquiry made into the matter.—Mr. G. Balfour: My attention has been drawn by the question to the proceedings at the inquest referred to in the first paragraph. The Clerk of the Union states that the woman was received into the workhouse in December, 1893, as a presumably destitute person in exchange for another person sent from the workhouse to the lunatic asylum. The woman did not belong to the Belfast Union. The reply to the fourth paragraph is in the negative. No such certificate is required. As to the fifth paragraph, no consultation is held regarding the condition of patients between the medical officers of the two institutions. I understand the medical officer of the workhouse stated at the inquest that he had heard that the Inspector of Lunatics had described the recreation yard in the manner mentioned, but I have not ascertained from the Inspector of Lunatics whether he has been correctly reported.

Treatment of Imbeciles in Ireland.

Mr. Engledew asked the Chief Secretary to the Lord-Lieutenant of Ireland whether the Government had decided what steps they intend taking with regard to the recommendation made by the Inspectors of Lunatics and Commissioners of Control in the report dated Lunacy Offices, Dublin Castle, January 8th, 1896, as to the great want, existing in Ireland, of a national institution for the training and education of idiot and imbecile children, in order that these classes might be removed from what the report of the Commission describes as the neglect and poverty of their own homes and from the contaminating influence of association with the adult inmates of asylums and workhouses.—Mr. Gerald Balfour replied that he was aware of the views expressed by the Inspectors of lunatic asylums on the subject of providing State aid towards the establishment of an institution for the training and education of idiots and imbeciles in Ireland. The matter was one which had his sympathetic consideration, and he hoped to be able at some time to introduce legislation dealing with it.

Inquiry into the Irish Workhouse System.

Mr. M'Cartan asked the Irish Secretary whether he would state if it was his intention to appoint a departmental or other Committee to inquire into the Irish workhouse system; and, if so, whether this inquiry would extend to the treatment of pauper lunatics in workhouses, and their admission to workhouses from properly equipped asylums; and whether he would give the names of the gentlemen who were to constitute this Committee.—Mr. G. Balfour: In the event of the passage of the Poor Relief (Ireland) Bill, inquiry would have to be held into the subject of the best means of grouping workhouses with reference to amalgamation, but I do not think it would be necessary to appoint a departmental Committee to inquire into the whole system of workhouse administration or to extend it to the treatment of the insane in workhouses or asylums.—Mr. A. O'Connor asked whether the inquiry would include classification.—Mr. G. Balfour said he did not think it would touch that point. He thought they had sufficient information in regard to it already.—Mr. Swift MacNeill: Will the inquiry cover the question of the consolidation of workhouses?—Mr. G. Balfour: My idea would be that the Committee or Commission should inquire as to what unions it would be best to group together.

Tradesmen as Attendants in Irish Lunatic Asylums.

In reply to Mr. Engledew, Mr. G. Balfour said that the Inspectors had from time to time drawn the attention of the Boards of Governors to the great importance of adding tradesmen attendants to the asylum staffs with a view to increasing the employment of the patients. At present, out of 722 attendants employed in the various asylums of Ireland 176 were tradesmen.

The Dismissed Asylum Attendants.

Mr. Field asked the Chief Secretary whether he was aware that the Board of Governors of Richmond Asylum on the 6th May dismissed James Duffy and Frederick Brunton because they refused to give up membership of a trades' union which had been established in connection with their employment, and registered on the 20th April; and whether he will have an inquiry instituted into this matter.—The Chief Secretary: The fact is as stated in the first paragraph. The appointment and dismissal of asylum attendants devolve by law upon the Board of Governors alone, and I see no sufficient reason for instituting an inquiry into the matter as suggested.

The Government Grant for Lunatics.

Mr. Ashton asked the President of the Local Government Board whether he had caused inquiry to be made into the question of extending the 4s. grant per week for lunatics, now given to lunatic asylums, to workhouses; and, if so, whether he was prepared to recommend that that grant should be paid for lunatics in workhouses who had been treated in asylums and discharged to workhouses as incurable.—Mr. Chaplin: I have received a large number of communications on this subject, and have given careful consideration to it. Nothing, however, could be done in the matter without an alteration in the law; and at present I am not prepared to propose legislation with regard to it.

PENSIONS AND GRATUITIES.

Poor Law Officers' Superannuation Act.

Dr. Murray Lindsay draws our attention to this Act, which, he remarks, should be useful to us and may help forward our cause, for it contains some principles we are advocating and should like to see applied to the asylum service, viz.:—

- 1.—Compulsory superannuation. Sec. 2.
- 2.—Compulsory retirement. Sec. 2, paragraph 3.
- 3.—Transferred service to reckon towards pension. Sec. 4.

4.—Power to add a number of years not exceeding ten in certain cases for peculiar professional qualifications or special circumstances. Sec. 5.

5.—Power to grant gratuities in certain cases. Sec. 8.

6.—Power of appeal to Local Government Board to decide questions as to the right to or the amount of superannuation allowance. Sec. 18.

7.—“Emoluments,” including the money value of any apartments, rations, or other allowances, to be reckoned in calculating pension. This is compulsory as part of the superannuation and not permissive or discretionary.

The scale is one-sixtieth for every year of service, the maximum of two-thirds not being attainable till after forty years' service; and there is an annual contribution to the Pension Fund of 2, 2½, and 3 per cent. according to the length of service. Sec. 13.

From the asylum point of view of course this could not be considered liberal or satisfactory, as asylum officials devote their *whole time* to the service; but from the Poor Law Officers' point of view, it may be considered fairly good as ensuring a *certainly*, for the Act applies to Poor Law Officers who are not required to and who do not devote their whole time to Poor Law service (*e.g.* Medical Officers), and whose work is much less arduous and risky than the Asylum service.

NOTICES BY THE REGISTRAR

EXAMINATION FOR THE CERTIFICATE IN PSYCHOLOGICAL MEDICINE.

The following candidates were successful at the examination held on the 16th July, 1896:—

ENGLAND.

Examined at Bethlem Hospital, London.—Edward John Cross, Anthony Alexander Martin.

SCOTLAND.

Examined at the Royal Asylum, Edinburgh.—John Clarke Nixon, William Hector Mackenzie, Sreenagula Mallannah, Ian Lamont MacInnes, Harold Sherman Ballantyne.

Examined at the Royal Asylum, Aberdeen.—William Ainslie, Robert H. Clarke, William Deane Manson Donald, William Marshall Philip, Thomas Snowball, George Felix Thompson.

The following were the written questions:—

1.—Give the predisposing causes, symptoms, prognosis and treatment of Puerperal Mania. 2.—Describe briefly Primary Dementia, giving its course and prognosis. How does it resemble and differ from Melancholia with Stupor, and from Secondary Dementia? 3.—In what cases are hallucinations of sight and hearing most frequently met with? To what extent would they influence your treatment and prognosis of a case, and what precautions would you deem necessary in such cases? 4.—An act of outrage has been committed by a man known to have suffered from Epileptic “Fits”: what circumstances would go to prove that the perpetrator was an irresponsible agent? 5.—Describe a case of Acute Delirious Mania, and state how you would distinguish it from a case of delirium tremens. 6.—State your views as to the causes of change in pupils observed in General Paralysis of the Insane.

The next examination will be held in December, 1896. Due notice of the date will be given in the *Lancet* and the *British Medical Journal*.

WINNER OF THE GASKELL PRIZE

William Richard Dawson, M.D.

The following were the written questions:—

1.—Give in detail the pathological changes found microscopically in the Cerebral Convolutions and Meninges in General Paralysis of the Insane. 2.—What are the mental symptoms which occur in Myxœdema? How do you explain them? What is the cerebral pathology of this disease? 3.—Define

"Judgment." What is the difference between Judgment and Reasoning? What is the relation to Judgment of (a) Hesitation and (b) Doubt? 4.—To what morbid changes are the cells of the fifth layer of the Cortex liable, and in what form of insanity are these cells specially affected? 5.—Is there a distinct form of insanity which may properly be termed homicidal mania? If so, describe its characters and show how it differs from other forms of insanity accompanied by homicidal propensities. 6.—To what extent may the advent of puberty be regarded as a cause of insanity? What do you consider to be the mode of its operation?

WINNER OF THE BRONZE MEDAL.

John Turner, M.B., C.M.

THE CERTIFICATE IN NURSING.

The next examination for the Certificate of Proficiency in Nursing will be held on Monday, the 2nd day of November, 1896, and candidates are earnestly requested to send in their schedules, duly filled up, to the Registrar of the Association, not later than Monday, the 5th day of October, 1896, as that will be the last day upon which, under the rules, applications for examination can be received. For further particulars respecting the various examinations of the Association apply to the Registrar, Dr. Spence, Burntwood Asylum, near Lichfield.

ERRATUM.

The name of John McCool was erroneously included in the list of attendants who had passed the July examination.

OBITUARY.

DR. COLIN MACIVER CAMPBELL.

We deeply regret to have to record the death of Dr. MacIver Campbell, lately Medical Superintendent of the Perth District Asylum. His resignation in 1893, when the state of his health rendered it impossible for him to continue to discharge duties for long undertaken under the gravest difficulties, caused widespread regret and was a serious loss to the Institution, the interests of which he had cared for so well. His father, the Very Rev. Principal Campbell, of the University of Aberdeen, was a man of marked ability, and his sons might have aspired to eminence in any walk of life. None, however, reached middle life, and Dr. Campbell was the last survivor of six brothers, deeply mourned by all who had the advantage of his friendship during his too short career of usefulness.

He was educated at the University of Aberdeen and Vienna, and served as Assistant Medical Officer in the York Retreat and the Durham County Asylum besides serving in the West Riding Asylum as Clinical Clerk. When Dr. Campbell entered on his duties at Murthly in 1883, he brought ability, skill and training to carry on the work in which he was so deeply interested, and soon endeared himself in all the relations of life to those with whom he was brought into contact. His generous kindly nature had been shattered by a long and terrible illness, and for many months before death relieved him of the burden of life, his bright and sunny disposition was almost overwhelmed by disasters.

Dr. Campbell did not write much. His energies were rather devoted to the immediate considerations of asylum management. He placed on record certain

observations relative to the influence of Typhoid Fever on insane patients; and was one of those who produced the *Handbook for Attendants* in 1885. A noteworthy feature of his rule at Murthly was the institution of a school for the patients, managed by the neighbouring schoolmaster in such a way as to really interest those for whom the benefit was intended. His able administration of the Perth District Asylum was duly recognised by the District Lunacy Board entering on their minutes their appreciation of his services and the regret with which they had received the intimation of his death, which occurred at Edinburgh on the 20th June, 1896.

DR. FRANÇOIS SEMAL.

Dr. François Semal, the celebrated Medical Superintendent of the State Hospital for Insane Women at Mons, who died the 16th of May, 1896, was born at Brussels the 20th December, 1835. He took his diploma in 1860 and entered the Belgian Army. Soon afterwards he gave proof of his great mental activity, and was presented at the Exhibition of Hygiene of London with a diploma of honour for his study of epidemic diseases. In consequence of his careful treatment of patients suffering from cholera at Antwerp, he received Stars of the Orders of Belgium, Prussia and Holland.

In 1869, Dr. Semal left the army and was at once appointed Medical Superintendent at the Asylum of Mons, where he remained for twenty-seven years. In the same year was created the "Société de Médecine Mentale," of which he was an original member, and he took a great part in the discussions of that learned body. Its Bulletins contain many important original papers by Dr. Semal, while others were rewarded by the Royal Academy of Medicine of Belgium and the "Association Medico-psychologique de Paris." In 1873, Dr. Semal took an active part in the reform of the Belgian Lunacy Law.

The rebuilding and reorganisation of the asylum at Mons, was presided over by Dr. Semal, and the admirable character of this institution deserves the recognition of foreign alienists.

We understand that a full account of his life and work is shortly to appear, and express the regret of this Association at the loss of so distinguished an honorary member.

NOTICES OF MEETINGS.

South-Western Division.—The Autumn Meeting of this Division will be held at Fisherton House, Salisbury on the afternoon of Tuesday, October 20th. A discussion will be opened on "Constipation in the Insane."

Scottish Division.—The next Meeting will be held in Edinburgh on Thursday, 12th November, 1896.

The next *General Meeting* will be held on Thursday, November 19th, at the Rooms of the Association, 11, Chandos Street, Cavendish Square. W.

APPOINTMENTS.

Aberdeen University Court.—MR. GEORGE FREDERICK STOUT, Fellow of St. John's College, Cambridge, and Editor of *Mind*, has been appointed the Anderson Lecturer on Comparative Psychology in the University of Aberdeen on the terms recently mentioned in the columns of the *Lancet*.

Grahamstown Asylum, S. Africa.—DR. CHARLES G. CASSIDY has been appointed Assistant Medical Officer, *vice* Dr. Walter Adam, resigned.

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